

**OVERVIEW AND ANALYSIS  
OF  
KANSAS PUBLIC MENTAL HEALTH SYSTEM**

**June 1, 2009**

**The Department of Social and Rehabilitation Services  
Division of Disability and Behavioral Health Services  
Mental Health Services Program**

## Executive Summary

Serious mental illness affects the lives of tens of thousands Kansans and, if these people do not receive needed mental health services and supports, their ability to live successfully in their homes and communities is dramatically reduced. Mental illness not only affects persons with mental illness, but it has a profound impact on their families and friends, the local community, and the state at large. However, research demonstrates that recovery from mental illness is possible and should be expected. But, many people with severe mental illness do not have the financial means to pay for the treatment and services needed to support their recovery. Therefore, a comprehensive, effective, efficient public mental health system is needed to support persons with mental illness recover and live safe, healthy, successful, self-determined lives in their homes and communities regardless of their ability to pay.

Social and Rehabilitation Services (SRS) Mental Health Services' mission is to support, manage, oversee, and fund a broad array of providers and work with stakeholders to ensure that quality and effective public mental health services are provided in the most cost effective manner possible. This systemic report on public mental health services provides an overview of Kansas' public mental health system, relevant data analysis of current issues, and the recommendations contained in SRS' planning efforts.

SRS has undertaken intensive planning efforts to improve how the public mental health system provides a full array of effective supports and services. This planning effort, called the Hospital and Home Initiative, has resulted in numerous recommended action steps for improving public mental health services. SRS is coordinating these recommendations with the Governor's Mental Health Services Planning Council who, along with its subcommittees, also assesses the efficacy and sufficiency of Kansas mental health services.

A number of providers make up Kansas' public mental health service system including: community mental health centers (CMHCs), state psychiatric hospitals, private mental health providers, psychiatric residential treatment facilities, nursing facilities for mental health, residential care facilities, and community hospital inpatient psychiatric treatment programs. Kansas also has very active and affective family and consumer advocacy organizations. Together these entities help provide a strong public mental health system in Kansas. However, much more can be done to improve the lives of persons with mental illness.

Kansas serves far fewer than the estimated number of persons who experience a severe and persistent mental illness. This suggests that many more persons could benefit from mental health treatment and supports than are currently receiving them. Kansas compares favorably with other similar states on the federal National Outcome Measures. However, these outcomes have remained stagnant over the years. Kansas needs to expand the use of community based support services to improve critical life outcomes for people with mental illness. The goal of this effort would be to increase the number of persons with severe and persistent mental illness who are living independently and working; increase the number

of children with a serious emotional disturbance who live in families and attend school; and reduce the number of Kansans with mental illness who are homeless, precariously housed, or incarcerated.

CMHCs provide community based public mental health safety net services to a large number of persons who do not have the ability to pay. These services are the backbone of the public mental health service system. CMHCs provide a comprehensive array of critical services that support persons with mental illness recover and live successfully in the community, especially those who are uninsured. However, these services vary widely across the state. It is important to determine if this variance in services affects the mental health consumers' quality of life, usage of inpatient psychiatric services, and/or if it affects the CMHCs' financial stability. Also, the number of uninsured is growing and the mental health grants to support them are declining. Steps need to be taken to focus CMHCs' efforts on ensuring persons in the target population receive the mental health services they need.

Mental health providers cannot provide quality services if they are not financially viable. Some mental health providers are experiencing serious financial hardships. Steps need to be taken to help these struggling private providers and CMHCs improve their financial condition. In addition, the Hospital and Home Initiative Core Team recommends that SRS seek regular recurring budget enhancement requests to adjust funding for public mental health providers to address rising costs associated with inflation and to pay sufficient wages to recruit and retain qualified staff.

The number of persons admitted to state psychiatric hospitals has nearly doubled since state fiscal year 2002. The increased demand for services is stretching their resources and may at some point threaten the quality of treatment. This issue will, in part, be addressed by improving the CMHC screening and assessment to better connect people with effective community based services. In addition, improved community crisis services will likely help reduce the demand for these limited services.

Community hospital inpatient psychiatric services could assist with reducing admissions to state psychiatric hospitals and serve persons closer to their homes and their support systems. However, the number of the licensed psychiatric inpatient beds has dropped from 443 in FY 2002 to 335 in FY 2008 and SRS has recently been notified of the recent loss of another 19 beds. SRS is attempting to address this by requesting a budget enhancement to change the Medicaid payment structure to allow for longer lengths of stay in community hospital psychiatric programs. This will help reduce transfers from community hospitals to state psychiatric hospitals. The budget enhancement also proposes to pay for the cost of persons who are uninsured.

Private mental health practitioners are growing in number because of the establishment of community based mental health managed care. SRS and Kansas Health Solutions (KHS), the Medicaid Managed Care Organization, are planning for this trend to continue. This will be further encouraged by reducing some managed care processes. While generally seen as a good thing, increased numbers of private practitioners raise the challenge of quality care coordination. KHS is monitoring this potential challenge.

Community based mental health managed care has been independently assessed and determined to be a success. However, TriWest's independent assessment lists recommendations SRS will implement to further improve the program. The Centers for Medicare and Medicaid Services (CMS) has reviewed the SED Waiver and found it in compliance with all required assurances. However, CMS provided a list of recommended improvements for the SED Waiver. SRS will implement these recommendations as well.

Psychiatric Residential Treatment Facilities have successfully replaced Level V and VI facilities in providing residential mental health treatment for children and adolescents while maintaining the flow of Medicaid funding for these services. SRS is in the process of gathering outcomes data for PRTFs that assess how this new service has improved outcomes for children and adolescents with serious emotional disturbances.

NF/MHs continue to provide services in the same manner as they have for the last 20 years. However, mental health services have progressed significantly in those years. A new vision for NF/MHs needs to be developed that utilizes the skills, talents and dedication of NF/MH staff along with the rest of the mental health service system to better support the recovery of persons with mental illness.

The Kansas public mental health system is a highly complex and interactive system of services that support persons in their recovery from their mental illness and in living a quality life. This systemic report further describes these services and provides relevant data that reflects the state of the public mental health system as it currently exists. The report also summarizes recommended changes identified in SRS' mental health planning efforts that are intended to improve mental health consumer outcomes.

Note: Since the completion of this report, the United States has experienced the worst economic downturn since the Great Depression. As a result, State Revenues have fallen dramatically and state funding in many areas has had to be cut to balance the state budget. These include cuts for many Mental Health programs, especially those in CMHCs and State Mental Health Hospitals. These funding cuts have exacerbated all of the challenges identified in this report.

# The Public Mental Health Service System

## Introduction

Mental illness, especially severe mental illness, can be devastating to persons who are affected. Untreated mental illness results in people experiencing unnecessary disability, unemployment, substance abuse, homelessness, needless incarceration, and wasted lives. Mental illness not only affects the person, but it has a profound impact on their families and friends, the local community, and the state at large. The National Alliance on Mental Illness estimates that the economic cost of untreated mental illness in the United States is more than 100 billion dollars each year.

Research demonstrates that recovery<sup>1</sup> from mental illness is possible and should be expected. But many people with severe mental illness do not have the financial means to pay for the treatment and services they need to support their recovery. Therefore, a comprehensive, effective, efficient public mental health system is needed to ensure mental health treatment and services are provided to support persons with mental illness with their recovery and to assist them in living safe, healthy, successful, self-determined lives in their homes and communities regardless of their ability to pay.

SRS is Kansas' federally designated mental health authority. In addition, state law designates SRS as the department responsible for planning, administering, managing, and leading the delivery of Kansas' public mental health services. SRS Mental Health Services' mission is to support, manage, oversee, and fund a broad array of providers and stakeholders to ensure that quality and effective public mental health services are provided in the most efficient manner possible.

This report provides a systemic overview of the public mental health service system, relevant data analysis, and a review of the recommendations from SRS' planning efforts. This report does not provide specific in-depth analysis of any one part of the public mental health service system. Instead it provides a broad analysis of the whole system, relevant data on current issues, and what actions are needed to improve it. Likewise, this report does not focus on only one public mental health service funding source, but instead examines how all of the various funding streams support the public mental health system. As action is taken to improve the system, more specific in-depth data collection and analysis will be done to measure the improvement in supporting recovery and improving the quality of peoples' lives.

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<sup>1</sup> "Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again. . . . The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution" (Deegan, 1988)

## Program Overview

In Kansas all persons needing mental health services, especially persons with a severe and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED), receive services through the public mental health system without regard to their ability to pay. Over 120,000 Kansans receive public mental health services each year. A number of providers make up Kansas' public mental health service system including: community mental health centers (CMHCs), state psychiatric hospitals, private mental health providers, psychiatric residential treatment facilities, nursing facilities for mental health, residential care facilities, and community hospital inpatient psychiatric treatment programs. This paper will primarily address these public mental health service providers.

In addition, many mental health consumer and family organizations provide critical support for the mental health service system. These include, but are not limited to: the Governor's Mental Health Services Planning Council and its subcommittees, Consumer Run Organizations and their Association, the Consumer Advisory Council, Kansas' Chapter of the National Alliance on Mental Illness (NAMI), KEYS for Networking, mental health associations, and others. The community at-large also provides a variety of supports to persons with mental illness including, but not limited to: law enforcement, hospital emergency rooms, the Veterans Administration, emergency first responders, faith based communities, civic groups, etc.

In addition, many persons in jails, prisons, and juvenile corrections also experience mental illness. Ensuring these persons are not unnecessarily incarcerated due to their mental illness and ensuring they receive needed mental health services while in jail or prison is a significant challenge that needs to be further explored.

In FY2008, Kansas mental health providers received about \$391.7 million in public funds to provide needed mental health services. These funds come from a variety of different sources. Medicaid is the largest source of funding. Medicaid reimburses qualified, enrolled providers for covered Medicaid services provided to Medicaid eligible recipients. The Federal government covers 60 percent of the reimbursement and the state pays the remaining 40 percent. Because this is by far the largest source of funding, it will be a major focus of this paper. The next largest funding source is state general funds.<sup>2</sup> SRS awards most of its state funding to CMHCs to fulfill their statutory service requirements. SRS also awards state funds to support Consumer Run Organizations, family advocacy and support groups, and a community medication program. In addition, SRS contracts with several Kansas Universities to provide mental health research and training. SRS' support for the Universities comes from Medicaid administrative funding.<sup>3</sup>

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<sup>2</sup> State general funds for this purpose include state general funds and Children's Initiative Funds (CIF). CIF are funds from the state tobacco settlement that are used for specific designated purposes.

<sup>3</sup> Federal Medicaid pays 50% of the cost to the state to manage and administer Medicaid programs. Research and training done by Universities are critical in managing Medicaid funded mental health services.

Kansas counties provide the third largest source of public mental health funding. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides the smallest portion of public mental health funding. The following chart illustrates the amounts of these various funding sources for state fiscal year 2008 (FY 2008). The chart shows specific mental health programs that receive direct funding either through Medicaid, state funding, or direct state appropriations. These include: Nursing Facilities for Mental Health, Psychiatric Residential Treatment Programs, Community Hospitals Inpatient Psychiatric Programs, and State Psychiatric Hospitals.

<b>PUBLIC MENTAL HEALTH FUNDING</b>	<b>FY 2008</b>
Medicaid Funding for Community Mental Health	\$182,982,532
SRS Grants & Contracts Funded with State Funds	\$42,893,605
SRS Grants & Contracts Funded with Medicaid Administrative Funds	\$8,452,639
County Funding (Calendar Year 2007)	\$25,422,000
SRS Grants & Contracts Funded with Federal Block Grants	\$2,976,478
SRS Grants & Contracts Funded with PATH Housing Funds	\$300,000
Nursing Facilities for Mental Health	\$14,484,069
Psychiatric Residential Treatment Facilities	\$38,098,981
Community Hospitals Inpatient Psychiatric Services	\$15,800,000
State Psychiatric Hospitals Excluding Forensics <sup>4</sup>	\$60,324,719
<b>Total</b>	<b><u>\$391,735,023</u></b>

### Community Mental Health Centers

Community Mental Health Centers (CMHCs) are charged by statute with providing the community based public mental health services safety net. Kansas statutes empower county government to designate or establish CMHCs, which every county has done. These statutes require CMHCs to serve all persons who need community mental health services without regard to their ability to pay. Many counties have joined together to designate a single CMHC that covers multiple counties resulting in the 105 counties designating or establishing 27 CMHCs. In addition to providing the full range of outpatient clinical services, CMHCs provide comprehensive mental health rehabilitation services such as psychosocial rehabilitation, community psychiatric supportive treatment, and peer support, case management, and attendant care. Rehabilitation services, case management, and attendant care have been proven to be key factors in supporting people with an SPMI in their recovery. In FY 2008 Kansas CMHCs provided services to about 35,040 adults with an SPMI and children with an SED.

Kansas law designates CMHCs as the gatekeeper for admission to state mental health hospitals. Under contract CMHCs also carry out similar functions for nursing facilities, nursing facilities for mental health, psychiatric residential treatment facilities, and Medicaid funded community hospital psychiatric services. CMHCs are surveyed and licensed by SRS.

<sup>4</sup> Forensics includes the state security hospital that does court ordered competency evaluations and treatment for prisoners and inmates, and the sexual predator treatment program.

### State Psychiatric Hospitals

The state psychiatric hospitals – Osawatomie State Hospital (OSH), Rainbow Mental Health Facility (RMHF) and Larned State Hospital (LSH) – provide the inpatient public mental health safety net. They serve persons experiencing serious symptoms of severe mental illness that CMHCs have determined are a danger to themselves or others and whose symptoms of mental illness cannot be treated safely and effectively in the community. Once the persons' severe symptoms of mental illness are stabilized, they can successfully return home with supports provided by their CMHCs or other mental health providers. The state psychiatric hospitals are accredited by the Joint Commission and are approved (i.e., certified) to participate in federal Medicaid and Medicare funding. The State Psychiatric Hospitals also provide forensic evaluation and treatment. Those forensic programs are not a subject of this report.

### Private Mental Health Providers

On July 1, 2007, with the inception of the community based mental health managed care program, additional access to Medicaid funding was made available to licensed mental health practitioners. Private practitioners provide Medicaid covered clinical mental health outpatient services to Medicaid eligible beneficiaries. These practitioners provide primarily therapy and medication management services. A significant number of these practitioners are associated with child welfare contractors. The independent review of the Community Based Medicaid Managed Care Program identified that at the end of FY 2008 the number of non-CMHC private mental health practitioners in the Medicaid program has expanded to 970. Of these 412 of the private mental health practitioners are associated with child welfare contractors and 558 are private practitioners. This trend has continued. As of March 2009 there were 1,291 private practitioners of which 500 are from child welfare and 791 are other private practitioners. As a result Medicaid eligible recipients now have a wider choice of Medicaid mental health service providers.

### Community Based Mental Health Medicaid Managed Care

SRS manages its Medicaid funded community mental health services through a managed care program. SRS has contracted with a managed care organization - Kansas Health Solutions (KHS) - to administer the community based mental health managed care program. KHS' primary role is to process claims and make payments to providers and to ensure Medicaid recipients receive the right community mental health service at the right time in the right place in the right amounts provided by the right person. The community based mental health managed care program provides consumers a greater choice of providers while maintaining the foundation of the public mental health system. The community based mental health managed care program has also allowed Kansas to fund specialty services, like peer support and attendant care services, that are critical to supporting mental health recovery. KHS also pays the CMHCs to do admission screenings for persons potentially needing state mental health hospital placement, persons who are Medicaid eligible or potentially eligible seeking inpatient psychiatric services in community hospitals, and youth potentially needing placement in a PRTF. The community based



mental health managed care program also administers the state funded MediKan community mental health services for persons applying for federal disability benefits, the Home and Community Based Services Waiver for Children with a Serious Emotional Disturbance (SED Waiver), and the Psychiatric Residential Treatment Facility Community Based Alternatives (PRTF CBA) grant.

### Psychiatric Residential Treatment Facilities

Psychiatric Residential Treatment Facilities (PRTFs) provide comprehensive mental health treatment to youth who, due to mental illness, substance abuse, or severe emotional disturbance are in need of treatment that can most effectively be provided in a residential treatment setting. Youth seeking treatment in a PRTF are screened by a CMHC to determine the need for this level of treatment and whether or not the youth's immediate needs cannot be appropriately and safely met by community based services. The residential treatment facility is expected to work actively with the family and other agencies to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the residents. Once the youths' mental health symptoms are stabilized, the PRTF and the CMHC plan and arrange to provide community based services that will allow the youth to successfully return to their families and communities where they can receive community based mental health services. PRTFs are licensed by the Department of Health and Environment with SRS' assistance in reviewing compliance to mental health active treatment standards.

### Nursing Facilities for Mental Health

Nursing facilities for mental health (NF/MHs) provide out-of-home residential care and rehabilitation treatment for persons experiencing severe symptoms of mental illness. NF/MHs provide around the clock supervision, care, and treatment for persons with mental illness needing this level of service. CMHCs screen persons applying for admission to NFs/MH to determine if they need this level of residential care and treatment. In addition to determining functional eligibility, the screening evaluates whether community based services could provide sufficient supports and services that would allow them to live successfully in their home and community. NF/MHs are surveyed and licensed by the Department of Aging based on nursing facilities standards.

### Residential Care Facilities

Residential Care Facilities (RCFs) provide housing and needed supports to persons with mental illness that cannot find their own housing and/or who need staff support to live successfully in the community. RCFs do not receive state or federal funding. All services are funded by fees charged to the residents who pay the fees predominately from federal Supplemental Security Income or other disability benefits. SRS licenses RCFs. Licensing standards are in the process of being updated to improve health and safety requirements. Because they receive no public funds, RCFs will not be a part of the detailed report.

## Community Hospital Inpatient Psychiatric Treatment Programs

Some community hospitals provide inpatient psychiatric treatment to persons in their communities. The CMHC screens Medicaid eligible or potentially eligible persons referred to these programs to determine if this level of care is needed. The most frequent admissions to these programs are persons experiencing a mental health crisis who cannot be effectively or safely served in a community setting. The community hospitals provide needed psychiatric treatment to stabilize the persons' symptoms of mental illness. Once severe symptoms are stabilized, they can successfully return home with supports provided by their CMHCs or other mental health providers. All hospitals are accredited by the Joint Commission. The Department of Health and Environment licenses psychiatric programs that are a general hospital. In addition to community hospitals, there are three "free standing" community psychiatric hospitals in Kansas licensed by SRS. Free standing psychiatric hospitals provide only inpatient psychiatric services. Two of these free standing psychiatric hospitals serve only children and adolescents and one serves adults.

## Planning and Program Improvement Efforts

Two years ago SRS established the Hospital and Home Initiative. This Initiative's Core Team was charged with providing advice and direction in developing a plan that identifies the necessary components of a comprehensive array of mental health services including inpatient treatment. The Core Team is made up of a cross section of consumers, family members, advocates, and state agencies staff. The Core Team's planning efforts have been coordinated with the Governor's Mental Health Services Planning Council (GMHSPC) and become part of Mental Health Services' Federal three year action plan. Some of the Core Team's activities included:

- Determining long and short term indicators of success
- Determining parameters for a University of Kansas study
- Researching, reviewing, sharing, and discussing a plethora of data, existing studies, reports, papers, etc
- Reviewing the preliminary and final findings of the University of Kansas study

The Core Team chartered smaller Work Teams to develop recommendations in the following areas:

- Screening, Assessment, and Discharge from Inpatient Services
- Crisis Services
- Access to Supports and Services

The Work Teams were made up of a cross section of mental health stakeholders similar to the Core Team and were led or co-led by a mental health consumer. In May 2008 the Work Teams issued their reports to the Core Team. The Core Team summarized the Work Teams' recommendations in an Executive Summary. SRS then took the recommendations of the Work Teams and compared them with the recommendations from the GMHSPC, the

Joint Solutions Group, and CMHC needs assessments<sup>5</sup>. There was a high degree of correlation between the recommendations of these groups.

The Core Team was reconstituted to include most of the members of the original Core Team plus additional representatives that included more consumers and family members, community hospitals, Nursing Facilities for Mental Health, and providers. The newly reconstituted Core Team was charged with overseeing the implementation of the Work Team recommendations. In response the Core Team began organizing the Work Team recommendations by:

- Grouping similar Work Team Recommendations together
- Determining who should take the lead on each recommendation
- Prioritizing the recommendations

Numerous recommended action steps emerged from this process that the Core Team and Work Teams believe will improve recovery for persons with mental illness. Many of those recommended actions are referenced in this report. SRS was designated as the lead agency for these six top priority action steps:

- Improving the payment system for community hospital inpatient psychiatric services;
- Supporting local entities in expanding the availability of safe, decent, affordable housing for persons with disabilities (referred to as “Creating Homes for Kansans”);
- Establishing a new Vision for NF/MHs;
- Adopting and implementing the Screening, Assessment, and Discharge Work Team Recommendations;
- Assessing the extent to which Crisis Services, as defined by the Crisis Services Work Team, are provided in Kansas; and
- Ensuring there are post discharge services available for persons with multiple complex needs once they have successfully completed inpatient mental health treatment.

While these efforts are beginning, the Core Team has started developing outcome measures that will help determine whether or not the implementation of these action steps have a positive impact on the lives of persons with mental illness. The following three overarching outcomes have been preliminarily identified:

- Consumers will experience minimal disruption in their lives by maintaining their homes, occupation, financial stability and personal relationships;
- Consumers experience satisfaction with themselves, their world, and their dreams/aspirations; and
- Consumers experience recovery and live safe healthy successful self-determined lives in their communities

The Core Team’s next task is to determine what measurements will indicate whether or not these overarching outcomes are being achieved through implementation of the Work

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<sup>5</sup> The Joint Solutions Group is made up of SRS, State Hospitals, CMHCs, and KHS. The Group meets to discuss solutions to identified problems with screening, admission, and discharge of persons from state psychiatric hospitals. Statute requires that each year the CMHCs assess the mental health service needs of persons in their catchment area and report those needs to SRS.

Team's recommended actions. Once this has been completed, the Core Team will monitor the implementation of the action steps recommended by the Work Teams.

The Governor's Mental Health Services Planning Council and its Sub-committees also support the planning and evaluation process of Kansas' mental health services. This diverse, independent body evaluates the provision of mental health services and provides recommendations to the Governor and Secretary of SRS regarding possible improvements. Specifically the Council's duties include:

- Serving as an advocate for adults with serious mental illness, children with a serious emotional disturbance, and other individuals with mental illness or emotional problems.
- Conferring, advising, and consulting with the Secretary of SRS with respect to the policies governing the management and operation of all state psychiatric hospitals and facilities and community-based mental health services.
- Monitoring, reviewing, and evaluating, not less than once a year, the allocation and adequacy of mental health services within the state.
- Planning, reviewing, and evaluating mental health services in this state, as may be requested by the Secretary of SRS or as may be prescribed by law.
- Consulting with and advising the governor, from time to time, with reference to the management, conduct, and operations of state psychiatric hospitals and community mental health programs.
- Visiting and inspecting state psychiatric hospital and other providers of community-based mental health services;
- Making annual reports to the Governor and members of the Legislature and making recommendations as it deems advisable for appropriate legislation.

The Council also evaluates the federal mental health block grant application and provides feedback for consideration by the Substance Abuse and Mental Health Services Administration (SAMHSA).

## Prevalence of Mental Illness

According to the Surgeon General's report 9 percent of adults have an identifiable mental illness that results in significant functional impairment.<sup>6</sup> About 7 percent of adults have mental health disorders that persist for at least a year. Approximately 5.4 percent of adults have a serious mental illness (SMI). SMI is defined as persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral or emotional disorder that resulted in functional impairment which substantially interfered with or limited one or more major life activities. Substance use disorders and developmental disorders are excluded from this definition.

Kansas uses the narrower definition of Severe and Persistent Mental Illness (SPMI) when describing the target population of persons to whom the public mental health system focuses its services<sup>7</sup>. The Surgeon General's report estimates that 2.6 percent of adults with an SPMI, which includes schizophrenia, bipolar disorder, or other severe forms of depression, panic disorder, and obsessive-compulsive disorder. Based on these statistics, the following chart shows the estimated number of Kansas adults directly affected by these various categories of mental illness.

Total Kansas Adult Population	Identifiable Mental Illness Persists at Least One Year 7%	Serious Mental Illness 5.4%	Severe and Persistent Mental Illness 2.6%
1,998,849	139,919	107,937	51,970

The Surgeon General notes that the prevalence of mental disorders in children and adolescents is not as well documented as that for adults. About 20 percent of children are estimated to have mental disorders that result in at least a mild functional impairment. Approximately 5 to 9 percent of children and adolescents ages 9 to 17 experience more severe functional mental health limitations, known as "serious emotional disturbance" (SED). Based on this estimate, between 29,000 to 52,300 children and adolescents in Kansas have an SED<sup>8</sup>.

The following chart shows the number of persons with an SPMI and SED Kansas CMHCs served in FY 2007. The chart also shows SRS' forecast of the number of persons with an SPMI and SED who will be served in the next three fiscal years.

Number of Adults with a SPMI and Children with an SED			
Fiscal Year	SED	SPMI	Total
2007 Actual	20,605	14,435	35,040
2008 Forecast	21,122	14,800	35,922
2009 Forecast	22,000	16,500	38,500
2010 Forecast	23,000	17,000	40,000

<sup>6</sup> "Mental Health: A Report of the Surgeon General" US Department of Health and Human Services 1999

<sup>7</sup> See "Attachment A"

<sup>8</sup> See "Attachment B"

## Findings and Recommendations

Kansas dedicates substantial amounts of state, county, and federal funds to serve adults with an SPMI and children with an SED. However, Kansas serves far fewer persons than are reflected in the Surgeon General's prevalence estimates. This conclusion is supported by the fact that as many as half of the persons admitted to state mental health hospitals were unknown to the CMHCs before their admission. Clearly a concerted effort is needed to reach out to more persons with a severe and persistent mental illness. SRS is optimistic that the new community based mental health managed care program will allow CMHCs and private providers to identify and serve more consumers needing mental health services. However, many persons in the target population do not qualify for Medicaid and are otherwise uninsured. Serving these uninsured adults with an SPMI and children with an SED requires adequate and targeted state and county funding designed to ensure their mental health service needs are met.

## National Outcome Measures (NOMs)

The SAMHSA requires states to report their state's performance related to national outcome measures. SAMHSA established these outcome measures, called the, National Outcome Measures (NOMs), as meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities. The NOMS also provide a standard way to compare outcomes between states. This report provides a comparison of Kansas NOMS with those of Oregon, Nebraska, Iowa, and Utah. These states were selected for comparison purposes for their similarity to Kansas in terms of rural population, poverty rates, and geographic diversity.

As recently as five years ago, two of the five comparison states were not even gathering or measuring these outcomes. Kansas has been gathering, reporting these outcomes for many years. While other state's comparisons for 2007 are not yet available, Kansas' report to SAMHSA on the NOMs is shown below:

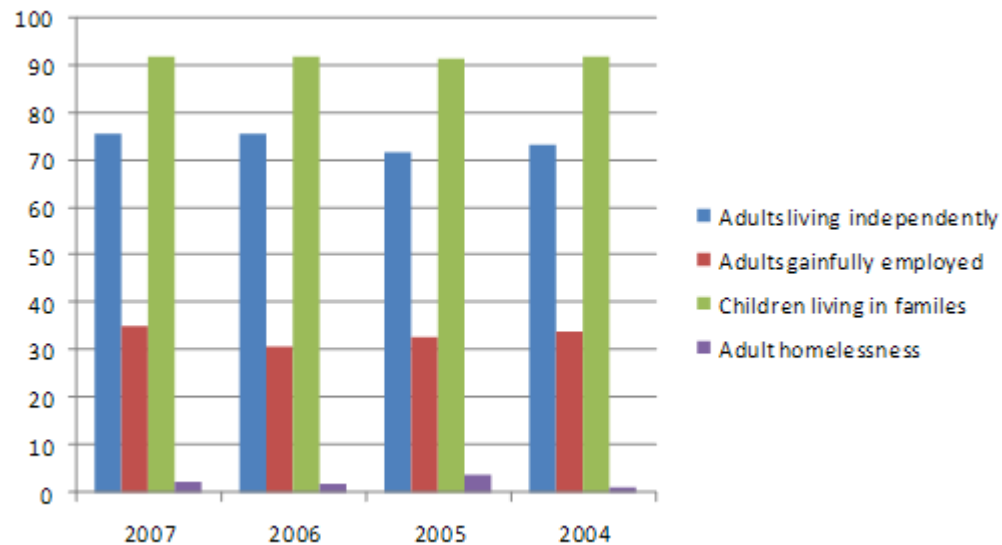
<b>NOMs 2007 REPORT FOR KANSAS</b>						
	Adults Living independently	Adults Gainfully employed	Children Living in Families	Adult homeless	Law enforcement contacts Adults	Law enforcement contacts Child
Kansas	75.6%	35%	92%	2.2%	6.8%	6.7%

The following comparable NOMS data is available for 2006, 2005, and 2004:

<b>NOMS 2006 REPORT</b>				
	Adults Living independently	Adults Gainfully employed	Children Living in Families	Adult homeless
Kansas	74.5 %	31%	92%	2.0%
Nebraska	80.6%	33%	81%	3.8%
Iowa	85.5%	29%	95.4%	0.8%
Oregon	NA	17%	NA	NA
Utah	84.9%	26%	92.4%	2.6%

<b>NOMS 2005 REPORT</b>				
	Adults Living independently	Adults Gainfully employed	Children Living in Families	Adult homeless
Kansas	71.7%	33%	91.5%	4.0%
Nebraska	86%	35%	NA	3.2%
Iowa	NA	31%	NA	05%
Oregon	NA	NA	NA	NA
Utah	85.5%	28%	94.5%	4.7%

<b>NOMS 2004 REPORT</b>				
	Adults Living independently	Adults Gainfully employed	Children Living in Families	Adult homeless
Kansas	73.3%	34%	91.9%	1.0%
Nebraska	78.6%	42%	88.4%	1.6%
Iowa	NA	NA	NA	NA
Oregon	NA	NA	NA	NA
Utah	87.7%	34%	95.5%	4.5%



## Findings and Recommendations

Kansas NOMS outcomes compare favorably with those of other comparable states. However, the trends are flat and it is reasonable to expect more progress in these areas.

### *Independent Living*

One of Kansas Health Solutions' (KHS) performance indicators is to decrease the utilization of institutional care. This includes Private, General and Specialty Mental Health Hospitals, State Mental Health Hospitals, Nursing Facilities for Mental Health, and Psychiatric Residential Treatment Facilities. KHS continues to make improvement in this area by emphasizing the use of both attendant care, and individual psychosocial rehabilitation service. Attendant care in combination with rehabilitative and outpatient services has allowed Kansans with mental illness to remain successfully in their home and community. It is expected efforts in these areas will improve Kansas' relatively low percentage of persons in independent living.

### *Employment*

Kansas continues to make significant strides in employment of persons with mental illness. Since 2002, Kansas has been committed to expanding evidence-based practice (EBP)<sup>9</sup> in supported employment (SE) statewide. Over the course of the last six years, supported employment EBP sites have increased to 12 CMHC sites. The University of Kansas School of Social Welfare Office of Mental Health offers training and technical assistance with the goal to help each CMHC's supported employment program enhance its adherence to evidence-based practice. KU also measures fidelity to the EBP at each CMHC site.

<sup>9</sup> See further explanation of EBP in the CMHC section this report



In 2008, 16 CMHCs participated in fidelity reviews and three were identified to be “Centers of Excellence.” Awards were given and those CMHCs received recognition for their achievements. This recognition process will continue to help sustain high performance in EBP.

Much of Kansas’ success at employing persons with mental illness is due to its EBP supported employment programs and peer programs such as Compeer, Consumers as Providers (CAP), and the Certified Peer Specialist (CPS) programs. Each program provides essential tools and training to help consumers become gainfully employed. The popularity and growth of the CPS program, which is a new part of our state Medicaid plan, has provided over 714 consumers with peer support during FY 08. These efforts need to be continued to raise Kansas’ already relatively high employment percentage

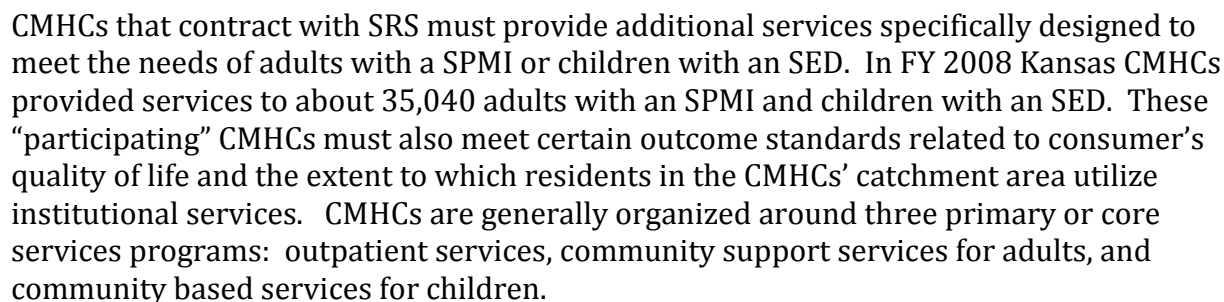
#### *Homelessness*

SRS recently co-sponsored a Homeless Point-in-Time Count that occurred in January 2009. The count found that an estimated 1,811 Kansans people that are literally homelessness. About 22 percent of those counted reported having a serious mental illness. The Governor’s Mental Health Services Planning Council has supported SRS’ efforts of addressing this homeless issue through the development of Creating Homes for Kansans (CHK) initiative. CHK’s vision is that all Kansans with disabilities have access to a full array of safe, decent, affordable, accessible and permanent housing options that are consistent with their needs and choice. The mission of CHK is to maximize funding opportunities at a grass root level so all areas of the state have affordable housing options. The Hospital and Home Initiative has established implementing the CHK initiative as one of its six top priorities.

#### *Children Living in Families*

The number of children in families has remained static for several years. Given Iowa’s success, Kansas needs to make additional efforts to improve its outcomes in this area. This will require the increased use of attendant care, individual psycho-social rehabilitation, and professional resource family homes for times when it is not possible for the child to remain in the birth family home.

Community Mental Health Centers (CMHCs) are charged by statute with providing Kansas' public community mental health safety net services. State statutes authorize local county governments to establish CMHCs in Kansas. The statutes authorizing the counties to designate CMHCs require them to provide basic mental health services to all persons without regard to their ability to pay. All Kansas counties have established CMHCs. Multiple counties may join together to establish a single CMHC to serve a larger geographic area. The 27 CMHCs range in size from those serving a single sparsely populated rural county to those serving large urban centers. The following map shows the catchment areas of the county designated CMHCs.



17

licensed clinicians. It also includes mental health medication evaluation and management.

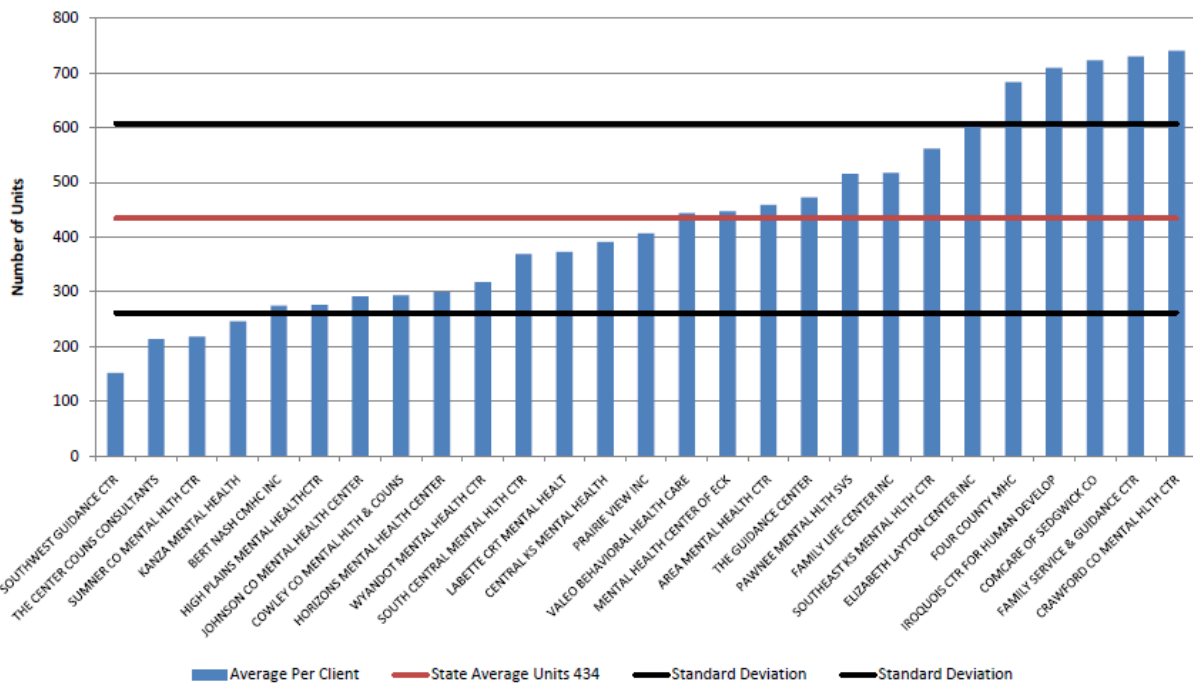
Community Support Services (CSS) provides a full range of mental health rehabilitation and support services for adults with an SPMI. CSS includes such services as community psychiatric support and treatment, group and individual psychosocial rehabilitation, peer support, and attendant care. These services are provided in the community wherever the consumer needs them. In many cases these services are supplemented by housing and employment services.

Community Based Services (CBS) provides wrap around services for children with an SED and their families. CBS services are specifically tailored to meet the needs of children and include such services as community psychiatric support and treatment, group and individual psychosocial rehabilitation, and attendant care. In addition CBS services provide services included in the Home and Community Based Services Waiver for Children with an SED waiver and the PRTF CBA grant. These services include such things as wrap around facilitation, independent living/skills building, parent support, respite, etc. These services are provided in the child's home, community, or school.

CMHCs also provide targeted case management services. Case management assist persons in gaining access to needed medical, social, educational, and other services. Activities include assessment, development of a treatment plan, referral, and monitoring and follow-up. Case management is the only Medicaid funded service that can assist a person to secure non-medical social or support services such as housing, vocational, educational, and other social services.

The extent to which CMHCs provide Medicaid funded CSS, CBS and Targeted Case Management services varies greatly. The following chart shows the average Medicaid units of service per year provided to persons receiving these services from CMHCs.

**Psycho-Social, Targeted Case Management, Personal Care Services,  
Community Psychiatric Supportive Treatment  
FY 2008**



Codes: H0036, T1019, T1017,H2017

Additional research is needed to determine the reason for this significant variance in the average amount of service. It is also important to determine what effect the different level of service has on how well people with mental illness experience recovery and live quality lives.

Many of CMHC programs provide services that are evidence based. Evidence Based Practice (EBP) is a term that refers to interventions that have been rigorously tested; have yielded consistent, replicable results; and have proven safe, beneficial, and effective for most people diagnosed with mental illness. CMHCs provide the following EBPs in Kansas:

Practice	Number of Sites
Strengths Based Case Management	8
Supported Employment	16
Integrated Dual Diagnosis Treatment	11
Pre & Post Booking Jail Diversion	6
Re-entry from Prison	8
Family Psycho-education	3

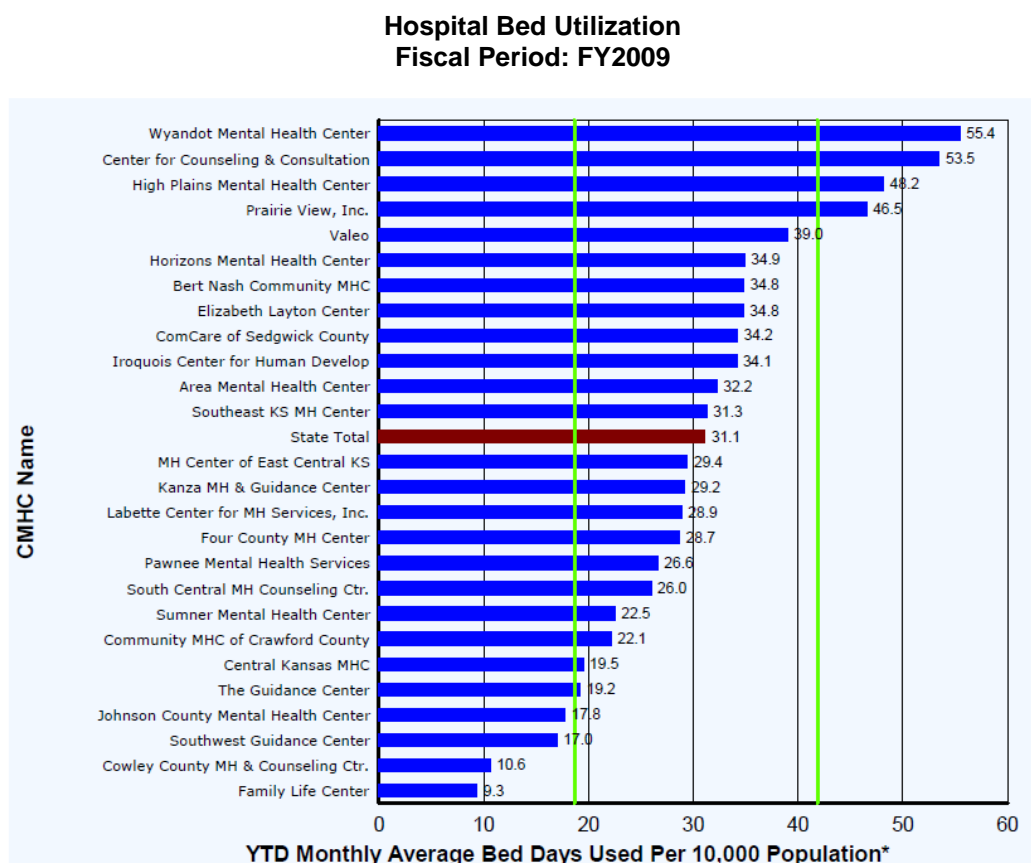
SRS supports the growth of EBP through research and training. One of the Hospital and Home Action Steps identifies the need to, “Develop and implement a plan for expanding evidence based practices (EBP) statewide, including EBP for children’s services, ACT (assertive community treatment) services for persons who experience repeated inpatient admissions, peer support and intensive case management services.” Medicaid

reimbursement for Community Psychiatric Support and Treatment is higher for those CMHCs who have achieved EBP fidelity for integrated dual diagnosis treatment, strengths based case management, and supported employment. SRS hopes these efforts will encourage the growth of promising and evidenced based practices in Kansas.

CMHCs also provide 24 hour emergency crisis services. Any person experiencing a mental health crisis can contact the CMHC in their catchment area anytime to get the services they need to address their crisis. Some CMHCs have mobile crisis services that go to where the person is to support them through their crisis. Some of these mobile crisis services are connected with local law enforcement Crisis Intervention Teams.

In addition to these core CMHC services, many CMHCs operate other programs that provide valuable assistance to persons with mental illness to recover and live safe, healthy, successful, self-determined lives. These include, but are not limited to: substance abuse treatment, housing, vocational training, Compeer, etc.

CMHCs are also designated as the “gatekeeper” for state psychiatric hospital services. CMHCs screen persons potentially needing state psychiatric hospital treatment to determine if they are a danger to themselves or others and whether or not their mental health needs can be safely and effectively met in a community based setting. The extent to which CMHCs utilize state psychiatric hospitals varies greatly. The following chart reflects these variances across the state:



In addition to screening for state psychiatric hospital placement, the CMHCs are also contractually responsible for screening admissions for Medicaid eligible or potentially eligible persons seeking inpatient psychiatric services in community hospitals, nursing facilities for mental health, and psychiatric residential treatment programs.

Public funding that is provided just for CMHCs comes from Medicaid, SRS grants and contracts, and county funding. The following provides a summary of the amounts of these funds:

<b>PUBLIC CMHC FUNDING</b>	<b>FY 2008</b>
SRS Grants & Contracts State Funds	\$37,716,357
SRS Grants & Contracts Federal Block Grants	\$2,465,801
County Funding (Calendar Year 2007)	\$25,422,000
Medicaid Mental Health Managed Care and Fee for Service	<u>\$144,623,456</u>
Total	<u>\$210,227,614</u>

Medicaid funding comes through the community based mental health managed care program. State and county grants and contracts provide funding for services to persons who do not have public or private insurance and do not have the means to pay for mental health services. Consumers without a means to pay are charged on a sliding fee schedule. Grant funds help defray the remaining cost CMHCs incur for serving all people who need mental health services regardless of their ability to pay. As noted below, the number of uninsured Kansans has been steadily rising.

	<b>FY 2001</b>	<b>FY 2007</b>
Percent of Uninsured Kansans	10.5%	12.5%

The increase in the number of uninsured Kansans makes it more difficult for CMHCs to meet their statutory mandate. In addition, cuts in the FY 2010 budget require that the state grants used to serve persons who are uninsured be reduced. This will make even more difficult for CMHCs to provide services to everyone seeking mental health services.

State funding for CMHCs has grown steadily in recent years. This growth is primarily due to increased use of Medicaid funding. On July 1, 2007 Kansas shifted how it manages Medicaid funding for CMHCs from a “certified match” program to a full payment program. Certified match was a process whereby the CMHCs “certified” they had available a portion of the required state match for Medicaid. In 2007 grant funds that CMHCs formerly certified were available for the state share of Medicaid were moved from grants to Medicaid. The CMHCs were then paid the full state and federal share of Medicaid and were no longer required to certify any of the required match. The following CMHC funding chart demonstrates this funding shift:

<b>Community Mental Health Center Funding</b>	<b>SFY 2006</b>	<b>SFY 2007</b>	<b>SFY 2008</b>
<b>State Funding</b>			
State Aid	10,233,297	10,233,297	10,233,297
Participating CMHC Grants Not Used for Match	7,627,780	1,506,611	21,874,340
Other CMHC Grants (2)	5,937,000	5,721,944	5,608,720
<b>TOTAL STATE &amp; FEE FUNDING</b>	<b>23,798,077</b>	<b>17,461,852</b>	<b>37,716,357</b>
<b>Federal Mental Health Block Grant</b>	<b>2,649,857</b>	<b>2,465,801</b>	<b>2,465,801</b>
<b>Medicaid Funding</b>			
Direct Medicaid Payments–FFP Only in FY 06/07	65,816,299	72,857,974	144,868,194
Medicaid Certified Match – Direct Grant	19,678,394	18,508,435	(1)
Certified Medicaid Match - Participating Grant	23,454,651	29,559,689	(1)
SED Waiver All Funds	25,441,367	27,484,427	(1)
MediKan	5,126,307	4,889,944	(1)
<b>TOTAL MEDICAID FUNDING</b>	<b>139,517,018</b>	<b>153,300,469</b>	<b>144,868,194</b>
<b>TOTAL STATE FUNDING</b>	<b>165,964,952</b>	<b>173,228,122</b>	<b>185,050,352</b>

1. Certified Match Grants were eliminated in FY 2008. Participating CMHC Grants were reduced by \$10 million and the funds were added to Medicaid to cover the needed state match. All payments made by the MH Managed Care Organization include both the full state and federal share.

The intention was for the shift to not adversely affect the CMHCs. However, those CMHCs that make greater use of Medicaid ultimately benefitted more from the shift. The shift adversely affected some of the CMHCs that access Medicaid less. SRS has been closely monitoring the CMHCs' financial health. Generally speaking about a third of the CMHCs are doing fairly well financially, about a third are holding their own, and about a third are struggling with three or four CMHCs experiencing serious financial difficulty. The cuts in state grants that will occur in FY2010 will exacerbate this problem. Some of the corollaries related to financially struggling CMHCs seem to include:

- Serving a smaller population area than other CMHCs;
- Relatively less county support than the average CMHCs;
- Lower utilization of Medicaid funding than the average CMHC either through
  - Serving fewer Medicaid beneficiaries or
  - Providing fewer services per beneficiary.

## Findings and Recommendations

### *CMHC Financial Viability*

It is critical that agencies providing public mental health services be financially viable. Financially healthy CMHCs are needed to ensure services are provided as they should to support mental health consumer recovery. To help assure this occurs, SRS is participating with the Association of Community Mental Health Centers of Kansas in providing consultation with CMHCs experiencing financial difficulty. The CMHCs have undertaken an intensive study, with the assistance of a nationally known expert, to determine the actual cost of providing mental health services, especially to the uninsured. This data will be invaluable to determining the actual cost of these needed services. The Hospital and Home Initiative recommends that SRS submit recurring budget enhancement requests to ensure that all mental health providers are reimbursed at reasonable appropriate rates that allow them to recruit and retain experienced qualified staff needed to support people in their mental health recovery.

### *State Psychiatric Hospital Use*

The Hospital and Home Core Team has recommended SRS undertake an effort to improve and standardize the screening and assessment process for determining whether or not a person should be authorized for admission to a state psychiatric hospital. It is believed an improved, standardized admission screening process will reduce unnecessary state psychiatric hospital admissions and perhaps reduce the variances in the usage of state psychiatric hospitals among CMHCs. SRS established a charter team charged with developing a plan to implement the improvements to the screening and assessment process recommended by the Hospital and Home Work Team. Part of this effort will ultimately result in standardized training for CMHC staff that are responsible for responding to people in a crisis and screening them for possible state hospital admission.

### *Service Variance*

SRS and KHS are also examining the wide variance in the amount of services provided by CMHCs. One focus of this effort will be to determine if the wide variance has any significant impact on the frequency persons are referred to state psychiatric hospitals. Clearly this will be a complex analysis. The data above indicates that those CMHCs that provide an average amount of services per person are the most likely to have fewer state psychiatric hospital referrals. There appears to be little evidence that CMHCs that provide high amounts of service per person consistently utilize state psychiatric hospitals at lower rates. Likewise, there appears to be little evidence that CMHCs that provide lower amounts of service per person consistently utilize state psychiatric hospitals at higher rates. The reasons for these unexpected findings will have to be further explored.

### *State Mandate*

Increasing numbers of uninsured and declining grants to fund those services is making it increasingly difficult for CMHCs to fulfill their service mandate. It appears increasingly likely that services will need to be focused on those uninsured persons with the greatest need - persons with an SPMI, children with an SED, or others experiencing a mental health crisis.

### *Quality of Life*

SRS will also evaluate whether or not the wide variance in CMHC services affects the quality of life of the persons they serve. Measuring the quality of life of persons with mental illness will require more sensitive measures of quality of life than are required by SAMHSA. The Hospital and Home Core Team is discussing consumer outcomes that will result in more sensitive measures of quality of life.



## State Psychiatric Hospitals

The State Psychiatric Hospitals – Osawatomie State Hospital (OSH), Rainbow Mental Health Facility (RMHF) and Larned State Hospital (LSH) – serve persons experiencing serious symptoms of severe mental illness. The State Psychiatric Hospitals provide the inpatient safety net for mental health services. They must accept and serve all persons with mental illness referred to them through CMHCs. The CMHCs are designated by statute as the gatekeeper responsible for screening persons who potentially need treatment at the State Psychiatric Hospitals. With few exceptions, only persons CMHCs determine are a danger to themselves or others and who cannot be safely and effectively served in the community are authorized for admission to the State Psychiatric Hospitals. Once the patients' severe mental health symptoms are stabilized, they can successfully return home with supports provided by their CMHCs and/or other mental health providers. In addition to these services, the State Hospitals also provide forensic evaluation and treatment which is not a subject of analysis in this report.

The State Psychiatric Hospitals are accredited by the Joint Commission and are certified to participate in federal Medicaid and Medicare funding. To qualify for federal funding the State Psychiatric Hospitals must ensure all patients are actively involved in their individually developed treatment plan and do not experience extensive idle time between treatment sessions. Ensuring this active treatment requires a significant number of direct care staff.

OSH serves adults from 46 eastern Kansas counties, including the most populous - Sedgwick, Shawnee, Wyandotte, and Johnson counties. OSH shares its catchment area with Rainbow Mental Health Facility. About 50 to 70 percent of the people OSH serves also need substance abuse treatment.

Rainbow Mental Health Facility (RMHF) provides inpatient psychiatric care to adults from five counties served by three Community Mental Health Centers.

Larned State Hospital (LSH) operates the following three distinctly different treatment programs:

### Psychiatric Services Program (PSP)

The PSP serves persons from 59 western Kansas counties and provides acute psychiatric inpatient services for adults, adolescents, and children. The program provides the same services as OSH and Rainbow for their respective catchment areas.

### State Security Program (SSP)

The SSP located in the Isaac Ray Building, serves the statewide needs of the Department of Corrections (DoC) and the Criminal Courts for forensic evaluation and inpatient psychiatric care. This program includes: a forensic evaluation unit, two acute psychiatric treatment units, and two psychiatric rehabilitation units for inmates of the Department of Corrections, a psychiatric unit for females, and a security behavior unit. The security

behavior unit serves patients from all the state hospitals whose behaviors are extremely dangerous, requiring the highest level of security.

#### Sexual Predator Treatment Program (SPTP)

The SPTP serves persons with a civil commitment through the Kansas sexual predator treatment laws for indefinite treatment. When persons successfully complete their treatment at the SPTP inpatient program at LSH, they are referred to the SPTP Transition program that is managed by LSH but is located on the grounds of the OSH.

The analysis below is limited to inpatient psychiatric services related to voluntary and involuntary civil commitment. It does not include forensics evaluation and treatment or the SPTP.

The State Psychiatric Hospitals' budgeted psychiatric services bed capacity and average daily census for the first half of state fiscal year 2009 is shown in the table below.

Psychiatric Services Population		Budgeted Bed Capacity	Average Census FY09 First Six Months
Osawatomie State Hospital	Adults	176	166
Rainbow Mental Health Center	Adults	50	40
LSH Psychiatric Services Program	Adults	79	78
	Adolescent	12	5
	Children	8	3
<b>TOTAL</b>		<b>325</b>	<b>292</b>

State psychiatric hospitals are experiencing increased admissions over the last several years as can be seen by the chart below:

	Psychiatric Admissions <sup>10</sup>						
	FY02	FY03	FY04	FY05	FY06	FY07	FY08
LSH	663	738	846	990	1,064	1,097	1,176
OSH	1,023	1,189	1,404	1,767	1,853	1,832	2,060
RMHF	513	588	715	671	664	671	810
<b>Total</b>	<b>2,199</b>	<b>2,515</b>	<b>2,965</b>	<b>3,428</b>	<b>3,581</b>	<b>3,600</b>	<b>4,046</b>

The increased admissions have caused a strain on the Hospitals' ability to provide needed services. Thus far they have been able to maintain Medicaid and Medicare certification through dedicated efforts of treatment staff. However, at current staff levels, they are struggling to maintain the improvements that have been achieved.

One of the reasons for this increase in admissions is due to the decrease in the number of community hospital inpatient psychiatric beds in the state as shown below:

<sup>10</sup> Does not include SPTP, State Security Hospital or Social Detox admissions.



Number of Inpatient Psychiatric Beds Licensed by the Kansas Department of Health and Environment							
Year	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
No. Beds	488	436	401	384	392	380	335

The CMHCs' utilization of state psychiatric hospitals varies widely. A study done by the University of Kansas, School of Social Welfare reported that the number of bed days used by residents of CMHC catchment areas varies greatly<sup>11</sup>.

The State Psychiatric Hospitals receive direct state appropriations to fund their services. In FY 2008 the three facilities' psychiatric services programs expended about \$60,324,719. Of this amount \$32.5 million is from state general funds, \$2.2 million is from direct fee for service charges to Medicaid, \$9.7 million is from other fees collected for services, and \$15.9 million is from Medicaid disproportionate share.<sup>12</sup> The State Psychiatric Hospitals are also subject to the CMS Institution for Mental Disease exclusion, so they do not receive Medicaid payment for persons ages 22 through 64 years of age.<sup>13</sup> The State Psychiatric Hospitals' budgets are highly scrutinized by the Governor's Budget Office and Legislative committees. They are not authorized to expend more than is appropriated.

### Findings and Recommendations

SRS is attempting to address state psychiatric hospital census issues in several ways. First, SRS submitted a budget request that would provide Medicaid payment for longer lengths of stay at community hospital inpatient psychiatric treatment programs and provide state payment for persons who have no means to pay for those services.<sup>14</sup> In this way persons can experience their entire inpatient treatment closer to home and potentially reduce the number of admissions to state psychiatric hospitals. In the absence of funding to support this request, SRS will engage the community hospitals providing inpatient psychiatric treatment in how to best utilize their services as they currently exist. The goal of these discussions is to make the best use of local community resources by recognizing their important role in public mental health services.

Second, the Hospital and Home Core Team chartered a Work Team to develop recommendations regarding improving the crisis services provided in local communities. One proposal would change statutes so there is a freer exchange of needed mental health treatment data during a crisis. Providers will be encouraged to work cooperatively with consumers to establish individual emergency treatment and crisis plans that could be shared when a mental health crisis occurs. SRS is also assessing the extent to which crisis services are being provided consistent with the Hospital and Home Work Team Crisis Work Team recommendations.

Third, some persons needing inpatient psychiatric treatment come from other service sectors such as nursing facilities, developmental disability providers, traumatic head injury providers, etc. In some cases people referred from these other service sectors are not

<sup>11</sup> See CMHC Section

<sup>12</sup> Disproportionate Share is a Medicaid payment made to hospitals who serve a high number of persons who cannot pay for their services.

<sup>13</sup> See Nursing Facility for Mental Health Section

<sup>14</sup> See Community Hospital Section

accepted back to their home community once their inpatient treatment has been successfully completed. As a result these people stay much longer in state psychiatric hospitals than necessary. The Hospital and Home Initiative has recommended that SRS take action to ensure these people are accepted back to their home community when their inpatient treatment has been successfully completed. SRS will be undertaking this high priority recommendation this year.

Fourth, SRS researched data indicates that more than 50% of all persons admitted to state mental health hospitals have co-occurring substance abuse. SRS has contracted with a Regional Drug and Alcohol Center to provide intensive case management services to persons with co-occurring substance abuse who were discharged from OSH. This effort has demonstrated promising results. Based on this, the Hospital and Home Core Team has recommended the development of intensive case management across the state to better support people experiencing these challenges.

## Private Mental Health Practitioners

One of the goals of community based mental health managed care was to increase the number of providers consumers could choose from to receive their outpatient clinical services. The Community Mental Health Managed Care Program administered by the managed care organization, Kansas Health Solutions (KHS), does not limit the provider network. Instead KHS contracts with any qualified licensed mental health treatment provider. This is intended to increase access to mental health services and the choice of providers.

Prior to the establishment of community based mental health managed care only psychiatrists and doctoral level psychologists were authorized to bill Medicaid for community mental health services. Community based mental health managed care expanded this private provider network to include everyone licensed to practice mental health clinical services by the Board of Healing Arts and the Behavioral Sciences Regulatory Board. This expansion included such licensed mental health clinicians as Clinical Marriage and Family Therapists, Professional Counselors, Masters Level Psychologists, Masters Social Workers, etc.

By the end of FY 2008 the number of private mental health practitioners in the Medicaid program, excluding the community mental health centers, has expanded from 654 to 970 – a 48 percent increase. Of these 412 are associated with child welfare contractors and 558 are private practitioners. In FY 2008, these practitioners received about \$5,389,277 in Medicaid payments. Data indicates this number has continued to grow since July 2008. As of March 2009 there were 1,291 private practitioners of which 500 are from Child Welfare and 791 are Other Private Practitioners.

### Findings and Recommendations

Only a limited number of issues have been raised related to this expansion of mental health outpatient service providers. Concern has been raised regarding the beneficiary registration process required by KHS. While this process is needed to measure key performance measures of managed care, it appears to be excessive and cumbersome, especially for offices with one or two practitioners. SRS and KHS are taking steps to address these concerns. Other concerns have been raised regarding coordination of care for persons with severe and persistent mental illness and children with a serious emotional disturbance. This is because these people can receive their outpatient services by a provider different than the one who is providing mental health rehabilitation and support services. One of KHS' responsibilities is to ensure coordination of care. SRS and KHS are monitoring the quality of services being provided in these circumstances. In general, however, this expansion of access and choice has resulted in positive outcomes for persons with mental illness in Kansas.

## Community Mental Health Medicaid Managed Care Program

Kansas administers the vast majority of Medicaid funded community mental health services through a Centers for Medicare and Medicaid Services (CMS) approved community based mental health managed care program. The community mental health managed care program is part of a concurrent 1915(b) (c) freedom of choice waiver. Services administered through the community based mental health managed care program include all community mental health state Medicaid plan services, the 1915(c) Home and Community Based Services waiver for the children with a serious emotional disturbance (SED Waiver), and the Psychiatric Residential Treatment Facility Community Based Alternatives (PRTF CBA) grant. The community based mental health managed care program is administered by a managed care organization – Kansas Health Solutions (KHS) – under contract with SRS. KHS and its contracted providers are responsible to deliver its members the right mental health service at the right time in the right amount by the right person to support their mental health recovery and improved their quality of life.

The values and guiding principles of the community based mental health managed care program are that:

- The existing public mental health system and its infrastructure will be supported and enhanced.
- Community Mental Health Centers (CMHCs) will retain primary responsibility for meeting the needs of Kansans accessing the public mental health system.
- Persons with mental illness and their families will have a greater choice of outpatient providers including independently licensed practitioners and child welfare service providers.
- Interested stakeholders will continue to have many opportunities to participate in shaping public policies and implementation tools.

The services provided through the community based mental health managed care program include a full range of outpatient therapy, outpatient medical services, rehabilitation services, targeted case management, SED Waiver services, PRTF CBA, and 1915(b)(3) services including attendant care and case consultation. Rehabilitation services include community psychiatric support and treatment, psychosocial rehabilitation, peer support, and crisis intervention. These community based services are proven effective in assisting persons with severe mental illness experience recovering and live quality lives. Targeted case management ensures that persons with mental illness have the supports and services needed for success in all parts of their life. SED Waiver services include parent support and training, independent living/skills building, short term respite, wrap around facilitation, and professional resource family care. PRTF CBA services include all community mental health services, SED Waiver services, employment, and community transition services. Attendant care and case consultation are services specifically authorized as 1915(b) (3) services only available through the community based mental health managed care program. This package of services was specifically designed to ensure persons with mental illness have access to the full array of needed treatment, supports, and services.

The community based mental health managed care program was designed to provide members with a wider choice of outpatient therapy or medical services providers. KHS does not limit its provider network and seeks to contract with any qualified willing outpatient provider. Community based mental health managed care members can choose to receive their outpatient services from any one of the many KHS contract providers. Since July 2007 the number of non-CMHC mental health practitioners in the Medicaid program has expanded to 970. Of these 412 are associated with child welfare contractors. The chart below delineates out the practitioners.

Provider Type	Pre-Waiver	Post-Waiver						
	6/07	7/07	12/07	2/08	3/08	4/08	5/08	7/08
CMHC Staff	1,180	1,180	1,180	1,185	1,191	1,248	1,266	1,242
Independent Practitioners	654	652 <sup>15</sup>	439	436	447	503	519	558
Child Welfare Provider Staff	0	4 <sup>16</sup>	269	265	278	347	406	412
<b>SubTotal Non-CMHC</b>	<b>654</b>	<b>656</b>	<b>708</b>	<b>701</b>	<b>725</b>	<b>850</b>	<b>925</b>	<b>970</b>
<b>Total</b>	<b>1,834</b>	<b>1,836</b>	<b>1,888</b>	<b>1,886</b>	<b>1,916</b>	<b>2,098</b>	<b>2,191</b>	<b>2,212</b>

Since July 1, 2008, the number of non-CMHC mental health practitioners has grown to 1,291. Of these 500 are associated with child welfare contractors and 791 are independent practitioners.

CMHCs remain the primary provider of rehabilitation, targeted case management, SED waiver, PRTF CBA, and 1915(b) (3) services. The CMHC is required to provide or arrange to provide all of these services sufficient to meet the needs of members who seek services. If the CMHC is unable or unwilling to provide services, KHS can contract directly with another provider to deliver the services.

KHS is also responsible to ensure care is coordinated with other service systems. To achieve this requirement KHS and Value Options-Kansas, the substance abuse MCO, have a Memorandum of Understanding (MOU). This MOU includes specific guidelines for coordination of care of members with special health care needs to include those with co-occurring mental health and substance abuse issues, IV drug users, and pregnant women. The focus of this work is the Coordination of Care group which also includes the Medicaid physical health MCOs. This group meets regularly to develop ways to ensure care is coordinated between these different service systems. This process began with the development of a release of information that was needed due to very strict federal confidentiality regulations for those receiving substance abuse services. The starting point for this larger coordination of care effort including all of the MCO's and EDS has been with pregnant women with substance abuse and or mental health issues.

Next steps include:

- Agreement on talking points so messaging is standardized about this initiative;

<sup>15</sup> This total includes both independent practitioners and the individual practitioners from the four child welfare agencies reported. Reporting in this period combined these counts of individual practitioners. Reporting was broken out separately in subsequent periods.

<sup>16</sup> For this reporting period, the number of agencies was reported here, not the number of individual practitioners at those agencies. This discrepancy was corrected in subsequent reporting periods.



- Development of a plan of when and how to do outreach and education to each provider group; and
- Dissemination of the recently approved release of information as the means for this coordination of care to occur

Medicaid managed care is highly regulated. The state agency overseeing the program and the managed care organization must meet CMS stringent standards. The SED Waiver and the PRTF CBA must meet additional CMS requirements. The community based mental health managed care program has been reviewed by CMS and found in substantial compliance with managed care standards. The PRTF CBA was evaluated by CMS in March of 2008 and CMS will return for an expanded review in 2010. The SED Waiver has recently been reviewed by CMS and found in substantial compliance with all six CMS assurances. The SED Waiver will be submitted for renewal in June of 2010. Significant SRS and KHS resources are dedicated to meeting CMS' many requirements.

CMS also requires that the 1915(b) waiver be independently assessed before it is renewed. TriWest Group was engaged by the SRS to carry out the Independent Assessment based on requirements from the 1998 CMS document *Section 1915(b) (c) Waiver Program, Independent Assessments: Guidance to States*. Instead of doing its own programmatic in-depth review of community based mental health managed care, SRS is using the findings of this independent review as the basis for this report.

TriWest found that in its first year of operation the quality of services under the 1915(b) waiver program exceeded the quality of services prior to the waiver. The community based mental health managed care program's quality of care was assessed across 11 performance areas. The following describe the key results of TriWest's review of quality of care:

- The community based mental health managed care program enhanced quality oversight in the areas of:
  - Grievance and appeal system implementation - including the exemplary use of findings to make system enhancements;
  - Systematic assessment of critical incidents;
  - Exemplary implementation of outcome assessment for Medicaid members that improved on exceptional pre-waiver levels of oversight;
  - Improved member satisfaction for parents and caregivers of children served;
  - Exemplary monitoring of consumer involvement;
  - Exemplary expansion of evidence-based practices supported by fidelity monitoring;
  - Expanded mental health system leadership resources through the KHS;
  - Exemplary data reporting;
  - Expanded provider training; and
  - Expanded coordination of care activities.
- Performance results at pre-waiver levels were achieved in the areas of:
  - Claims timeliness;
  - Outcomes achieved; and
  - Member satisfaction for adults.

In no area of community based mental health managed care quality assessment did TriWest find performance below pre-waiver levels, and exemplary performance, at the highest range of Managed Care Program effectiveness that TriWest has assessed across multiple states, was achieved in numerous areas.

TriWest recommended the following as a result of its review of quality of care:

- Continue efforts to support aggressive reporting of grievances, but reconsider goal of 50% increase as potentially too high.
- Consider alternative means for monitoring adequacy of grievance rates, including:
  - Adding questions specific to grievances to satisfaction surveys, and
  - Requiring additional monitoring in catchment areas with very low rates.
- Consider revising critical incident reporting requirements so “unknown” deaths are more accurately characterized (e.g., “Medical Examiner Report Pending”) and potentially differentiated more precisely.
- Review desired performance levels in each area and consider differential monitoring approaches for areas with exemplary performance and those with greater opportunity for improvement.
- Consider revising the financial penalty provision for outcome areas with exemplary baseline performance (such as competitive employment) to focus on monitoring and possible financial incentives rather than penalties.
- Consider adapting the definition of the domains monitored in the satisfaction survey to match those prioritized by stakeholders, as long as the indicators monitored over time are sufficiently similar to allow for trending over time.
- Ensure that items on the satisfaction survey use multipoint likert scales and do not have a neutral choice option.
- Consider adding one question to the satisfaction survey on consumer involvement.
- Consider adding a metric for measuring capacity expansion of Evidenced Based Practices.

Access to community based mental health was assessed across 12 performance areas. The following describe the key results of TriWest’s review of access to care:

- The provider network was expanded significantly, including an exemplary 78% increase in available providers and broader access to Peer Support Specialists;
- There was adequate rates of post-waiver service penetration, documenting use of services by 12.7% of all members and establishing a successful monitoring system to monitor penetration ongoing;
- A process was implemented to monitor access to appointments that documented strong compliance with routine access requirements and the continued presence of pre-waiver gaps in emergent and urgent access;
- An exemplary monitoring of system capacity was established through the implementation of systematic monitoring of caseloads that exceed the requirements of any Medicaid mental health managed care plan with which TriWest is familiar, and that yield a wealth of data to identify trends and analyze access to care;

- Implementation of improved supports to enhance access including:
  - A customer service center to facilitate member access to and provider coordination of services;
  - Monitoring of inpatient days used, lengths of stay, and readmissions;
  - Systematic monitoring of service utilization that exceeded contractual requirements for their timeliness and met all other requirements including initial implementation of monitoring capacity for over/under utilization and retrospective review of cases with low levels of service use;
  - A systematic promotion of community based services team reviews;
  - Expansion of effective pre-waiver provider credentialing approaches to encompass the greatly expanded network;
  - More comprehensive provider manual distribution;
  - Provider satisfaction monitoring; and
  - Dissemination of provider information to members.

TriWest did not find any area assessed to be below pre-waiver levels. Furthermore, additional areas of exemplary performance were documented, at the highest range of Managed Care Program effectiveness.

Prior to the waiver, Kansas' mental health system was a fee-for-service delivery system. The introduction of the community based mental health managed care program was anticipated to result in substantial costs savings. Based on the actuary's experience in assisting other states in their implementation of managed care, SRS projected managed care savings of 16.73% (\$24.04 PMPM overall) or \$49,686,862, which were expected to be offset by increases in other costs [1915(b)(3)].

Incorporating all factors used in the methodology, the projections for Year One are shown in the table below, along with the Base Year data used to develop them.

Medicaid Eligibility Groups (MEGs)	Base Year (FY 2004-05)			Projected Year One (FY 2007-08)		
	Member Months	Cost	PMPM	Member Months	Cost	PMPM
SED	23,280	\$39,649,321	\$1,703.15	51,284	\$99,798,186	\$1,946.00
FC/Adoption	136,006	\$89,160,750	\$655.57	162,007	\$138,788,106	\$856.68
SSI	843,079	\$197,155,491	\$233.85	921,287	\$188,269,758	\$204.36
TANF	1,968,343	\$61,702,688	\$31.35	2,278,815	\$82,237,591	\$36.09
Administration	2,970,708	\$20,160,125	\$6.79	3,413,392	\$52,543,135	\$15.39
<b>Total</b>	<b>2,970,708</b>	<b>\$407,828,375</b>	<b>\$137.28</b>	<b>3,413,392</b>	<b>\$561,636,776</b>	<b>\$164.51</b>

In looking at the first year waiver cost and delivery of services, TriWest found the 1915(b)(3) waiver program is cost effective. TriWest also found that the community based mental health managed care program demonstrated evidence of improvement in the quality of and access to services, and overall costs are well below both the Base Year costs and Year One actuarial projections. There was no evidence of reductions in persons served or access, and there was instead evidence that access improved substantially. While there is some evidence that initial rate projections were too high, there is also evidence that the programs have reduced actual costs for inpatient care and controlled cost growth related

to prescription medication spending and program changes such as the addition of the psychiatric residential treatment facility benefit.

Overall, waiver costs were dramatically below projected costs. Projected costs for the approved waiver year and actual costs are shown in the table below along with member months and per member per month (PMPM) breakdowns. Comparing actual to projected costs, it is clear that the first year of the waiver was cost effective by \$254,511,313 overall, and the overall PMPM was 35% below projections. The PMPMs in each Medicaid Eligibility Group (MEG) category were also below projections, from between 21 to 44 percent.

Medicaid Eligibility Groups (MEGs)	Projected Year One (FY 2007-08)			Actual Year One (FY 2007-08)			Amount Below Projections
	Member Months	Cost	PMPM	Member Months	Cost	PMPM	
SED	51,284	\$99,798,186	\$1,946.00	35,494	\$44,658,370	\$1,258.19	\$55,139,816
FC/Adoption	162,007	\$138,788,106	\$856.68	153,032	\$73,034,735	\$477.25	\$65,753,371
SSI	921,287	\$188,269,758	\$204.36	753,023	\$121,763,858	\$161.70	\$66,505,900
TANF	2,278,815	\$82,237,591	\$36.09	1,921,371	\$43,134,790	\$22.45	\$39,102,801
Administration	3,413,392	\$52,543,135	\$15.39	2,862,920	\$24,533,709	\$8.57	\$28,009,426
<b>Total</b>	3,413,392	\$561,636,776	\$164.54	2,862,920	\$307,125,462	\$95.85	\$254,511,313

Overall, the large amount of savings over projected waiver costs seems attributable to four interrelated factors:

- The base year used to project waiver costs (FY 2004-05) represented the high point for behavioral health spending in Kansas, and therefore resulted in the higher initial starting point for the projection.
- The methodology used to allocate the base year costs attributable to allowable State Plan services resulted in a projection that was higher than actual costs.
- The changes in the State Plan resulted in reduced spending in services such as CMHC services at the same time the waiver were implemented.
- The community based mental health managed care program was able to control cost growth and in some cases reduce costs of care from pre-waiver levels.

TriWest also compared the relative cost of the community based mental health managed care program administration to services delivered by KHS. The community based mental health managed care program administrative costs are listed on the CMS-64.10 form. Since some community based mental health managed care program costs were embedded in the other State administrative costs (Line 19), a more detailed break-out of costs related to the community based mental health managed care program was examined. The detailed community based mental health managed care program analysis is summarized in the table below:

Cost Category	Pre-Waiver (FY 2006-07)	Waiver Year One (FY 2007-08)	Data Source
<b>Non-Waiver Administrative Costs</b>			
MMIS Operation	\$5,158,448	\$274,134	CMS 64.10
Other State Administrative Costs (Indirect costs from the Cost Allocation Plan)	\$15,001,677	\$9,731,071	CMS 64.10
<b>Mental Health Managed Care Program - Related Administrative Costs</b>			
Skilled Professional Medical Personnel	\$0	\$275,955	CMS 64.10
Preadmission Screening	\$0	\$2,401,862	CMS 64.10
External Review (EQRO) <sup>17</sup>	\$0	\$94,392	CMS 64.10
Other State Administrative Costs (Mental Health Managed Care Program Related)	\$0	\$11,756,295	CMS 64.10
Total Mental Health Managed Care Program Administration	\$0	\$14,528,295	
Total Administrative Spending	\$20,160,125	<b>\$24,533,709</b>	

Additional administrative spending for the community based mental health managed care program was just under \$11.8 million, well within the amount of savings achieved by the waiver programs over projections. This amount represents just 9.0% of the \$160,693,580 in overall spending on the community based mental health managed care program (\$146,165,076 for services and \$14,528,295 for administration). This administration amount is well within industry standards and represents a sound level of efficiency.

### Findings and Recommendations

TriWest provided the following recommendations regarding its review of service access:

- Monitoring for outpatient services should more clearly differentiate between the referral offered and the actual appointment kept. SRS may be able to simplify current standards to define a single performance threshold and apply it to three sets of events: the timeliness of the initial referral, the timeliness of the appointment offered (for routine care only), and the timeliness of the actual appointment.
- Maintain an emphasis on improvements to access in emergent and urgent care.
- Consider the appropriateness of monitoring emergent responses within two hours.
- Consider a more achievable goal for post-diversion follow-up, in addition to the overall 72-hour goal.
- Consider reporting all data going forward as rolling 12-month rates (rather than only quarterly rates).
- Maintain the exemplary reporting of provider to member service ratios, but assess over time if the burden of this monitoring in all areas is worth the payoff in quality findings it generates. As trends become clearer, some prioritization of reporting may be possible.
- Consider revising goals and the monitoring approach for State Hospital utilization in light of reductions in statewide private psychiatric inpatient capacity.
- Track use by payer type, to compare utilization by Medicaid recipients over time.

<sup>17</sup> EQRO costs also cover oversight of the Prepaid Inpatient Health Plan.

- Consider revising the performance goal of maintaining State Hospital use at all times below the FY 2005-06 level, examining broader trends in inpatient use (such as reduced overall private psychiatric hospital capacity), reviewing the role of the state hospital within that context, and establishing appropriate metrics for monitoring ongoing use on a quarterly basis and with breakouts by payer type so that Medicaid member trends can be tracked.
- Continue current efforts to improve the process for monitoring over and under utilization.
- Future satisfaction surveys should continue to use a multi-point likert scale, but should omit the neutral option for respondents in order to better differentiate satisfaction levels.

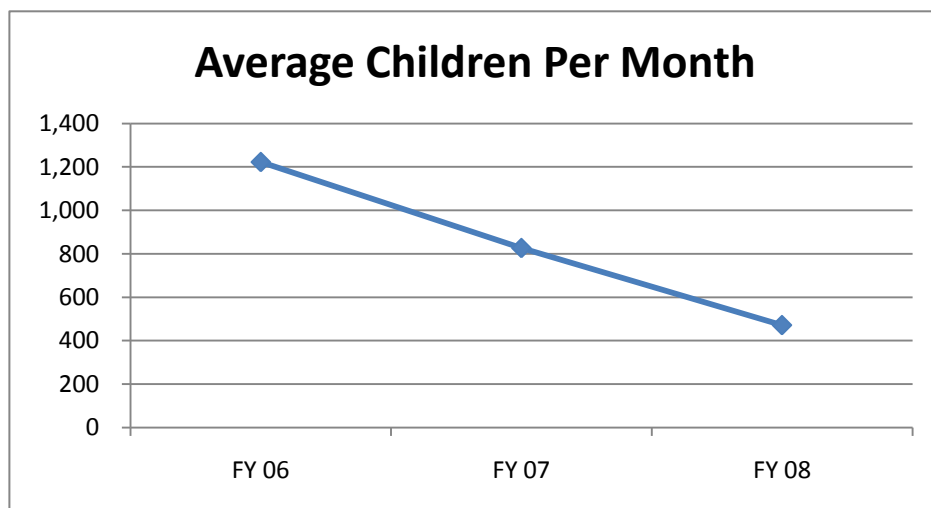
In addition, it was determined that the amount of certain services such as attendant care, peer support, and SED Waiver services for youth in custody and professional resource family care had not grown to the extent that was expected in the first year of the 1915(b)(3). Efforts are being made to address these areas. These efforts include SRS and KHS meeting with CMHC leadership during routine SED Waiver reviews to discuss issues or concerns that may be limiting the use of these services. SRS and KHS are also participating in training sessions for foster care contractors designed to help them become more familiar with SED Waiver services. SRS' Children and Family Services are also working with the Mental Health Services program to seek ways to expand professional resource family care homes.

SRS identified opportunities for improvement in the maintenance of peer support resources in a small number of rural/frontier catchment areas. SRS has a contract with Wichita State University that is designed to educate consumers regarding the benefit of peer support. Access to non-routine appointments in rural/frontier areas, development of more reliable reporting for private post-institutional discharges in facilities not under contract to the State, and expanded analysis capacity for over and under utilization are topics discussed with KHS. Plans are being developed by SRS and KHS to meet these needs. Through the collaboration of SRS, KHS, CMHCs and the University partners the effort of promoting medically necessary services and training for services is a positive ongoing strength of the community based mental health managed care program. The family centered, community based service focus continues to be an SRS, KHS and CMHC goal while supporting Kansans with mental illness to live self-determined, meaningful lives.

## Psychiatric Residential Treatment Facilities

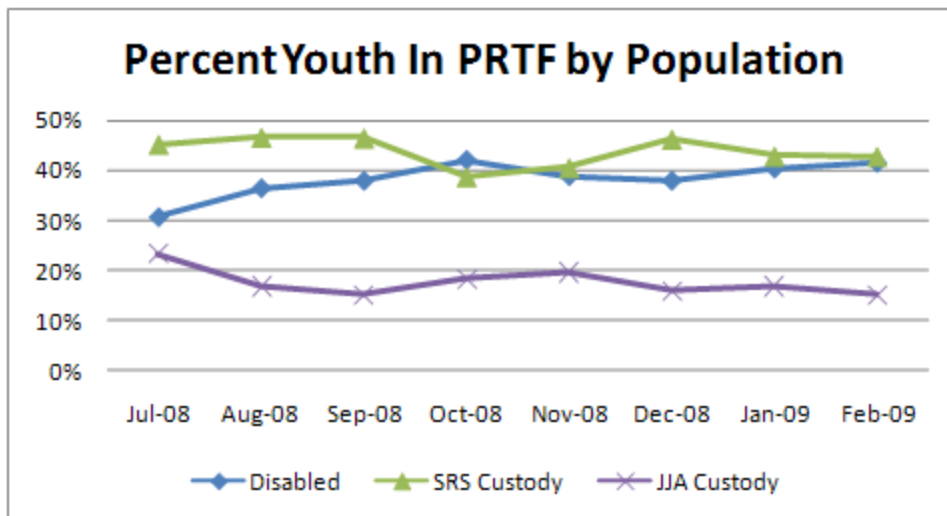
Psychiatric Residential Treatment Facilities (PRTFs) provide out of home residential psychiatric treatment to children and adolescents whose mental health needs cannot be effectively and safely met in a community setting. PRTFs must be accredited by a national accrediting body such as, but not limited to, the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. PRTFs must also meet stringent Medicaid certification requirements to qualify for Medicaid reimbursement. SRS reviews PRTFs to ensure compliance to these standards and, based on its findings, provides a licensing recommendation to the Kansas Department of Health and Environment who issues the license. Currently there are 14 PRTFs that operate in Kansas with 540 Medicaid certified beds. Medicaid pays for services provided in three (3) border facilities that make an additional 174 beds available for Kansas children.

Kansas has not always had PRTFs. Prior to July 1, 2007, Kansas funded residential psychiatric treatment through programs called Level V and Level VI facilities. The CMS determined that these Level V and VI facilities did not meet the requirements for Medicaid reimbursement and directed Kansas to change its method for classifying and certifying these facilities or discontinue claiming federal Medicaid funds for these services. In response Kansas established two classes of residential programs – PRTFs and Youth Residential Facilities (YRCs). PRTFs meet CMS' higher accreditation and certification requirements and are approved to claim Medicaid funding for the Medicaid recipients they serve. YRCs do not provide inpatient psychiatric treatment as part of their treatment milieu and do not claim Medicaid reimbursement for the residential care services they provide. As a result of these significant program changes the cost and utilization of PRTFs has changed dramatically. The chart below shows the significant change in utilization of PRTFs.<sup>18</sup>



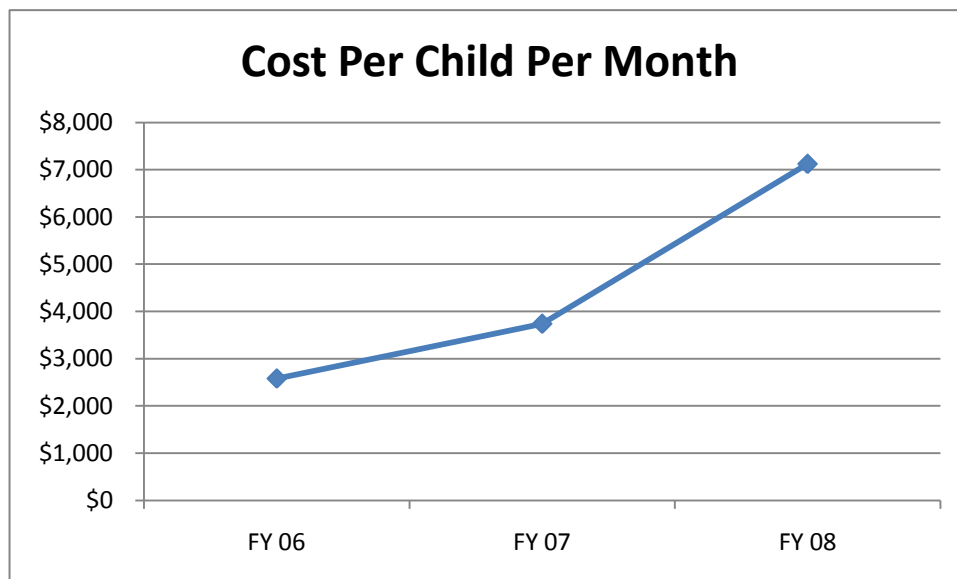
<sup>18</sup> PRTFs are budgeted in both SRS and JJA. JJA funds the cost of PRTF utilization for children in their custody and SRS funds all other placements.

Utilization went down significantly when two residential options were available for children. Children without serious psychiatric needs were placed in YRCs. The mix of who is served by PRTFs has shifted. As can be seen by the chart below:



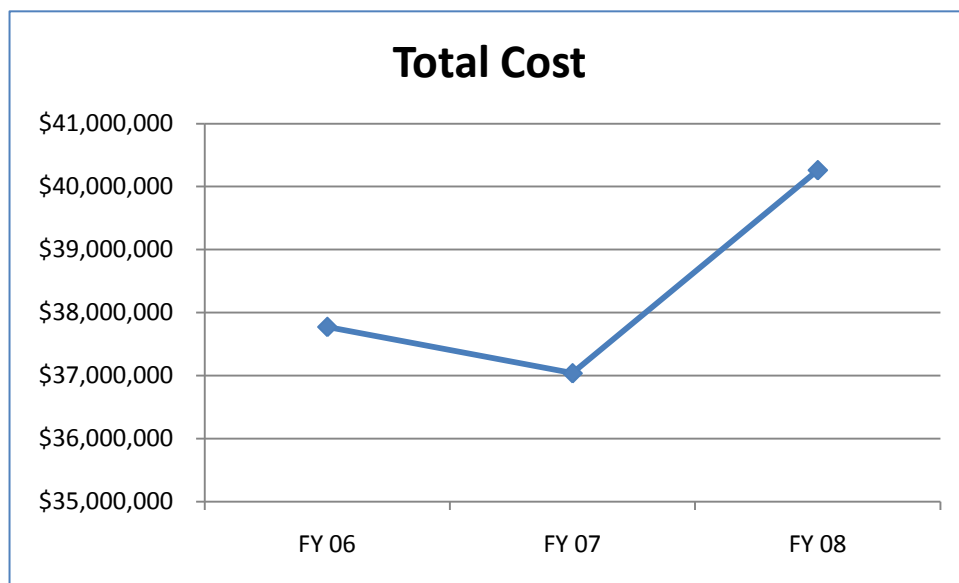
The Juvenile Justice Authority has significantly reduced its use of PRTFs. This reduction has been made up by an increase in the number of youth who are in the Supplemental Security/Social Security Disabled Medicaid eligibility population. This includes children who are SED some of which may have been on the SED Waiver. The use of PRTFs by children in SRS custody has remained relatively flat.

The cost per person in PRTFs increased dramatically over the former Level V and IV as a result of facilities having to meet significantly higher accreditation and CMS certification standards. The following chart demonstrates the increased cost per person.





The increased costs are primarily attributed to higher staff to resident ratios, greater number of nursing and professional staff, increased use of psychiatrists, etc. However, these cost increases are deceptive since, before the program change, many of these facilities were paid by Medicaid, outside their daily rate, for costs incurred for mental health services. PRTFs must provide all mental health services for the daily rate they are paid. In addition, while the total overall cost of PRTFs has increased, youth served in these programs receive significantly increased amounts of active treatment.



### Findings and Recommendations

The July 1, 2007 programmatic changes in residential psychiatric treatment for children and adolescents have resulted in the development of two different programs; YRCs that provide residential care but not predominately mental health treatment and PRTFs that provide residential psychiatric treatment. This change ensures only those children needing residential psychiatric treatment are placed in PRTFs. This has reduced the number of children receiving Medicaid funded residential treatment. PRTFs are required to meet significantly higher accreditation and CMS certification requirements. This has increased the quality and quantity of active treatment children in PRTFs receive. However, it has significantly increased the cost per child. As a result the overall cost of the PRTF program has risen significantly.

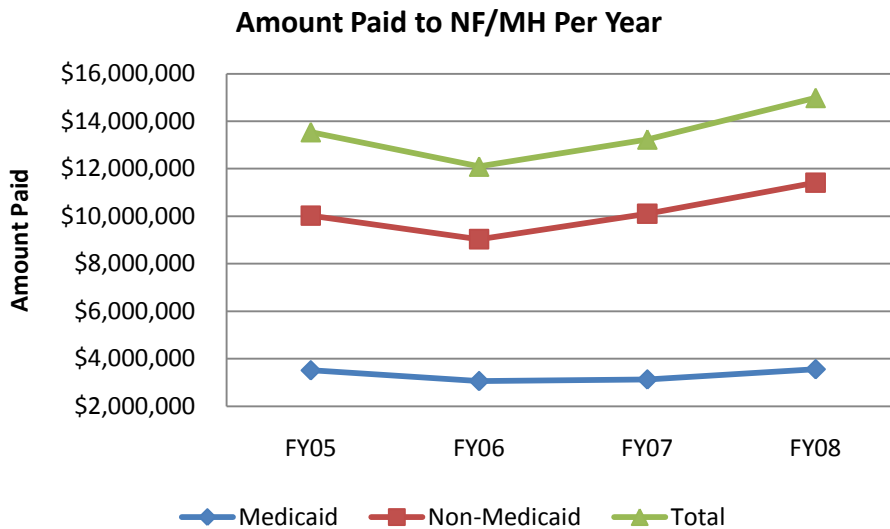
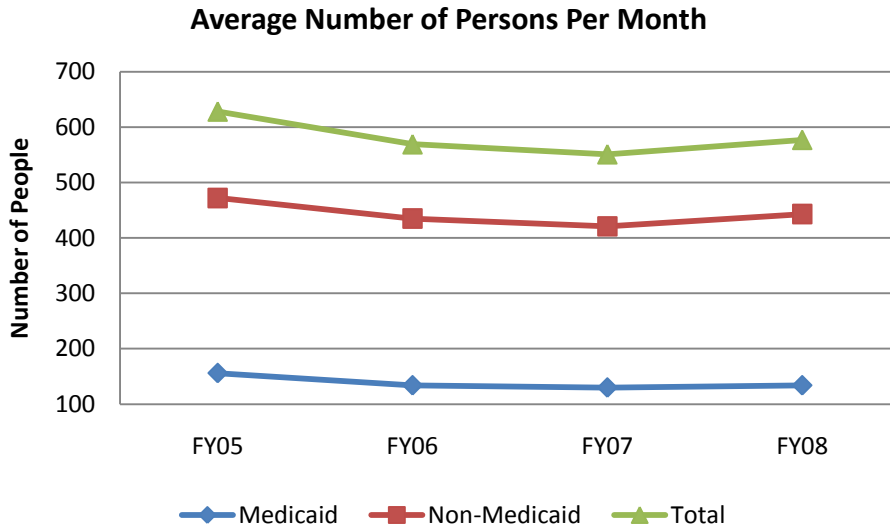
Mental Health Services has partnered with the University of Kansas and volunteer PRTFs to begin the process of assessing the extent to which this programmatic change has affected the quality of the lives of children served by PRTFs.

## Nursing Facilities for Mental Health (NF/MHs)

Nursing facilities for mental health provide residential care and treatment for individuals who, due to functional impairments related to mental illness, need skilled nursing care and special mental health services to compensate for activities of daily living limitations. The NF/MH program began in the early 1980's as an alternative to placing individuals with severe and persistent mental illness (SPMI) in nursing facilities that serve persons who are frail and elderly. For many years, NF/MHs have been major providers of residential treatment services for individuals with mental illness. The NF/MHs provide a resource for individuals who are unable to live successfully in the community without access to intensive levels of assistance available around the clock. These persons need a highly structured environment and mental health rehabilitation in activities of daily living that will help them re-integrate into community life. In addition, medication stabilization may be required for a longer period of time than the acute care provided in a state psychiatric hospital. The number of NF/MHs has decreased from 24 with a bed capacity of over 1,200 in 1991 to 11 with a bed capacity of 669 today. Kansas is the only state to have NF/MHs.

The Centers for Medicare and Medicaid (CMS) has defined facilities that are 16 beds or larger whose primary function is to treat mental illness as "Institutions for Mental Disease" (IMDs). CMS has determined that IMDs are the states' responsibility and prohibits Medicaid reimbursement for services provided in IMDs to individuals over the age of 21 and under age 65. CMS classifies NF/MHs as IMDs. Therefore, while the vast majority of persons in NF/MHs are Medicaid eligible, significant amounts of the funds paid to NF/MHs are not matched by federal Medicaid. Of the \$14,484,069 paid to NF/MHs in FY 2008, only about \$3.5 million was Medicaid funding. About \$11 million paid to NF/MHs was not matched by federal Medicaid funds because of CMS' IMD rule. This funding is provided with all state general funds.

Reimbursement for NF/MHs is determined in the same manner as reimbursement for nursing facilities that serve persons who are frail and elderly. NF/MHs submit cost reports that are adjusted to address the affects of inflation and then subjected to maximum limits. The daily reimbursement rate paid to NF/MHs ranges from \$78.81 to \$114.54. The following charts demonstrate the average number of persons served in NF/MHs and the total amount spent for the program.



As the charts indicate, the number of persons for whom Medicaid makes payment – those over 64 years of age - has remained steady or declined slightly during the last several years. However, the number of persons whose payment is made with all state general funds is steadily increasing. In addition, the amount of Medicaid matched funding has been steady or declining.

### Findings and Recommendations

The NF/MH model has remained virtually unchanged over 20 years. During that time treatment for persons with mental illness has improved significantly, the promise of mental

health recovery has emerged, and increased support for community based services has grown. In addition, most of the persons in NF/MHs could have had their mental health services funded by Medicaid if they were not served in NF/MHs. This raises the question of whether continuing to support persons in institutional care with non-matched funding is the best use of limited resources. Alternative use of available funding sources would potentially increase the amount of services and supports provided to persons with mental illness.

Staff and agencies providing NF/MH services are dedicated professionals with years of proven experience in serving persons with mental illness. It is now time to work with them to develop alternative service models to meet the needs of those they serve. One Hospital and Home recommendation is to “re-vision” the role of NF/MHs in Kansas. SRS has formed a Charter Group of NF/MH providers, consumers, family members, CMHCs, and other state agency staff to undertake this re-visioning process.

## Community Hospitals

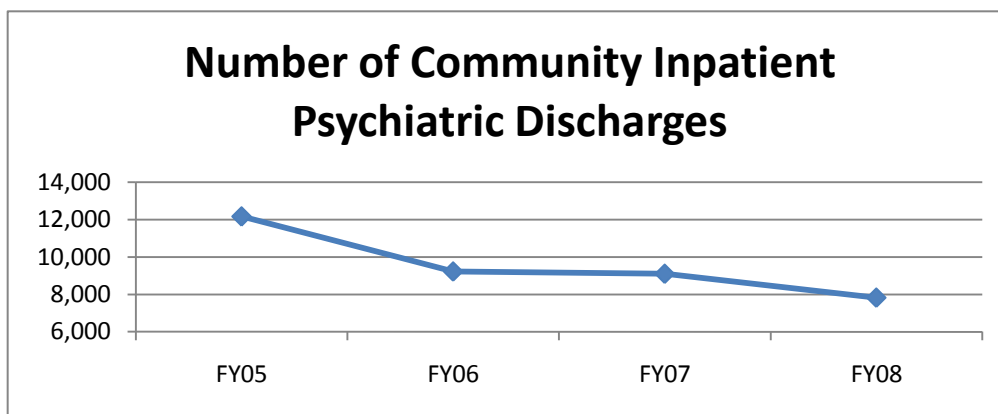
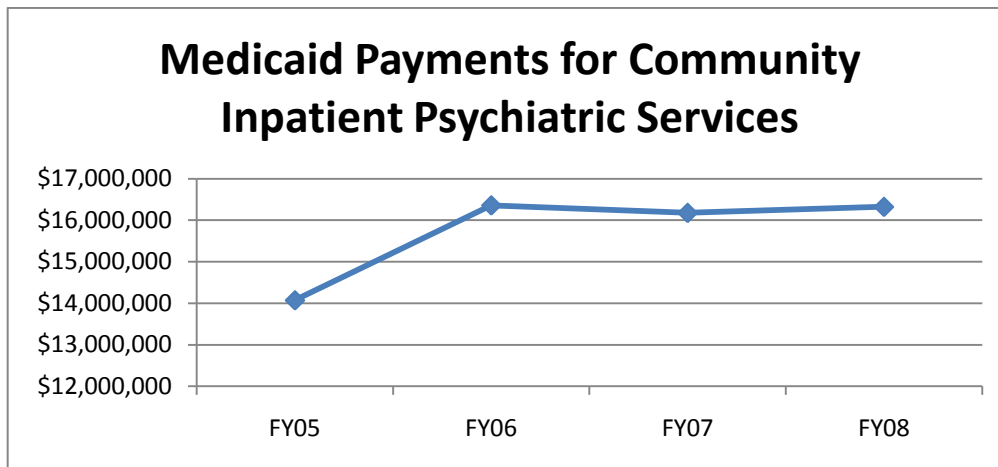
Community hospitals play an important role in serving persons with mental illness. Often people who are experiencing a mental health crisis will present themselves or be taken to a community hospital emergency department. When this occurs, the CMHC screens and assesses the person to determine what mental health crisis services the person needs. Little data exists regarding the extent community hospital emergency departments are used for mental health crisis and the challenges this is creating for the mental health consumer and the community hospital. The Hospital and Home Initiative has identified this as a piece of missing data that should be gathered and analyzed. As a result the role of community hospital emergency departments needs to be the subject of future study. This may emerge from the analysis of mental health crisis services called for in the Hospital and Home Initiative Crisis Services Work Team Report.

Some community hospitals also provide inpatient treatment for persons experiencing severe symptoms of mental illness. The goal of inpatient treatment is to reduce and stabilize the person's mental health symptoms so they can successfully return home with the support of community mental health services. Medicaid provides funding for these services through what are called "DRG" (Diagnostic Related Group) payments. The DRG system classifies hospital cases into one of approximately 500 groups expected to have similar hospital resource use. DRGs are used to determine how much Medicaid pays the hospital, since patients within each category are clinically similar and are expected to use the same level of hospital resources. The amount paid through DRGs is determined from hospital cost and length of stay reports. The resulting payment covers average reported costs for the average time a person stays in the hospital; which is approximately five days. The DRG reimbursement does allow for additional payments for persons who experience unusually long stays. But the added cost is not sufficient to cover the community hospitals' added costs of the longer stay. Other challenges with the DRG system have emerged in recent months. A change in how Medicare categorizes DRGs and the need to keep Medicaid inpatient payments level in Kansas has resulted in a 15% reduction in DRG payment rates. Coincidentally, another community hospital recently closed its 19 bed inpatient psychiatric program.

The following charts show the amount Medicaid paid to and the number of discharges<sup>19</sup> from community hospital inpatient psychiatric programs for dates of service FY 2005 through 2008.

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<sup>19</sup> Discharges are used instead of admissions because technically hospitals are paid by the discharge.



The total amount paid for community hospital inpatient psychiatric treatment has remained flat in recent years. However, the number of discharges has gone down. This reduction can be attributed to several reasons. The new community mental health Medicaid managed care program may be providing more community based mental health services that result in reduced demand for inpatient services. There are fewer community inpatient psychiatric hospital beds. Finally, hospitals have a history of not billing timely. Bills for some discharges in FY 2008 may not have been processed through the Medicaid payment system at the time this report was written. More research on this reduction is needed.

In addition to serving Medicaid beneficiaries, community hospital inpatient psychiatric programs also serve people with private insurance and some persons who do not have either private or public insurance and do not have the means to pay for their care and treatment. SRS does not have access to the number of persons community hospitals serve without payment. However, these persons, no doubt put a strain on the community hospital's financial resources.

Many people experiencing acute symptoms of mental illness are effectively served in community hospitals. However, the DRG payment limits payment to five days unless the person's stay is extraordinarily long. As a result, if the person is not stable and cannot

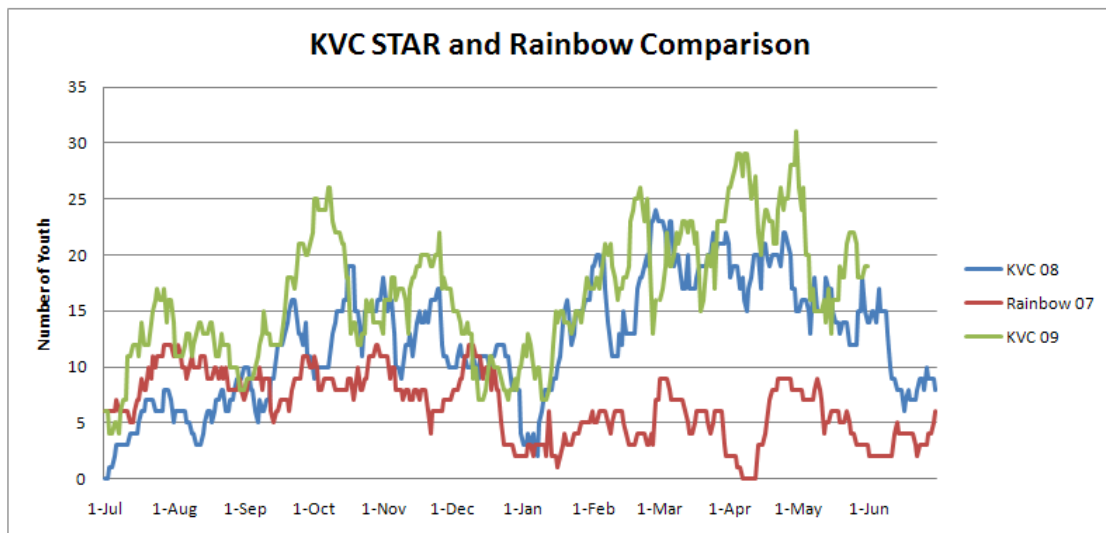
return home at the end of a short stay in a community hospital he/she may be transferred to a state psychiatric hospital. In addition community hospitals may need to refer some of the persons who do not have a means to pay for their treatment to state psychiatric hospitals. Finally, some patients present mental health needs that are more complex than the community hospital can effectively treat. These persons are also referred to the state psychiatric hospitals.

Data was collected for 500 admissions to OSH from January 21, 2007 through April 11, 2008. Of those 500 admissions, about 95 were from community hospital inpatient psychiatric programs. Assuming those admissions are representative of all OSH admissions, approximately 348 admissions from community hospitals would be expected each year. OSH's admissions represent roughly half of all state psychiatric hospital admissions. So, based on OSH's experience, all three facilities would be expected to have 696 admissions from community hospital inpatient psychiatric programs.

All previous mental health advisory groups, including the current Hospital and Home Initiative, have consistently recommended developing more regionally based inpatient mental health services. Other states have established private hospitals as a fully functioning part of their public mental health system by providing funding for treatment of persons who would have otherwise been referred to a state psychiatric hospital. These efforts have proven effective in serving persons closer to their home and reducing the number of admissions to state psychiatric hospitals.

Two projects are underway to begin to address this possibility in Kansas. In Sedgwick County SRS grants funds to the CMHC to purchase short term inpatient mental health treatment at a local community hospital for persons who do not have the means to pay for their treatment. This has prevented persons from being transported from Wichita to OSH for relatively short treatment stays. In many cases this has resulted in people being served closer to their home, family, and friends. Though small, this program has been very successful for the limited number of people who have been served.

In Kansas City SRS has entered into an agreement with KVC Behavioral Healthcare to provide inpatient treatment of children and adolescents who would have otherwise been referred to Rainbow Mental Health Facility. The program, called KVC STAR, accepts all youth referred to them and has agreed not to reject anyone unless it causes them to be above their licensed census. KVC is paid by Medicaid, Healthwave Title XXI, or private insurance for their services to these youth. SRS pays KVC state general fund payments for serving youth who do not have a payment source for their treatment. The following graph shows the KVC STAR program census in state fiscal year 2008 and 2009 compared to the Rainbow Mental Health Facility children's census in state fiscal year 2007.



The chart demonstrates that the number of youth served by KVC STAR consistently exceeded the number of youth served by Rainbow State Mental Health Facility the year prior to privatizing this service. The KVC STAR program has successfully served every youth referred to the program with only occasional isolated concerns being raised about the program. However, the increased demand for services remains unexplained and needs further investigation.

### Findings and Recommendations

To expand on these successes, SRS proposed a \$7.8 million FY 2010 budget enhancement to establish a new Medicaid payment method that would reimburse community hospitals for longer stays for inpatient psychiatric treatment admissions and to help pay the cost of persons who have no means to pay for their treatment. If this new approach is funded it would likely reduce the number of transfers from community hospital inpatient psychiatric programs to state psychiatric hospitals.

SRS needs to determine why KVC STAR is used at a higher rate than RMHF was when it served children. SRS is also looking at the possibility of replicating the KVC STAR program in western Kansas to replace the children and adolescent program located at Larned State Hospital.



## Summary and Recommendations

Mental Illness affects tens of thousands of Kansans. Without appropriate supports and services the lives of persons with mental illness, their family, friends and community can be devastated. However, recovery is possible and should be expected. A vigorous public mental health system is needed to provided services and supports for mental health recovery, especially for persons who do not have the means to pay.

Based on the Surgeon General's prevalence data there is a significant number of Kansans with an SPMI and children with an SED who are not receiving public mental health services. This conclusion is reinforced by the finding that about 50% of all persons admitted to state psychiatric hospitals have not been seen by CMHCs. SRS will work with service providers and KHS to increase the number served as forecasted in its annual SAMHSA report.

Kansas compares favorably with other similar states on the SAMHSA outcome measures. However, the relatively lower scores for adults achieving impendent living would indicate a need to increase the use of individual psychosocial rehabilitation and attendant care. This was confirmed through the cost effectiveness analysis and independent evaluation of the community based mental health managed care waiver. Reported homelessness of persons with an SPMI increased slightly in FY 2007. A more accurate assessment of homelessness will emerge from the Point In Time Homeless study co-sponsored by SRS. This need is being addressed by the implementation of the Creating Homes for Kansans initiative. The number of children with SED living in families has not improved for several years, suggesting the need to develop more and better services to support families and their children with SED. It is also believed that through the use of EBPs, Kansas can improve the percent of persons with an SPMI who are employed.

The Hospital and Home Core Team is establishing outcome measures to assess the effectiveness of the action steps recommended by the Work Teams. These outcome measures will go beyond and be more sensitive than those required by SAMHSA. It is expected that these outcome measures will more accurately measure the quality of life of people served by the public mental health system.

The CMHCs play a key role as the community based public mental health safety net. They serve over a 120,000 people with mental health issues, many who cannot pay for the services they receive. The quality of CMHC services is reflected in the generally positive SAMHSA outcomes. However, CMHCs vary widely in their size and capability. Significant research needs to be done to determine the extent to which these variances are contributing to:

- Variances in the financial viability of CMHCs,
- Differences in the use of state psychiatric hospital services, and
- Differences in the amount of service provided per person.

This analysis should include an assessment of whether or not these variances are also causing variation in the quality of life of persons with mental illness across the state.

In spite of these variances, however, it is important that all public mental health providers receive sufficient payment to provide effective and efficient delivery of needed mental health services. SRS will, when possible, seek budget enhancement requests to ensure this occurs. SRS will also work with the CMHCs on their project to better understand the actual cost of serving persons who are uninsured. SRS will also work with CMHCs to determine if, in these financially difficult times, the state mandate can be extended to everyone or will need to be limited only to those who are the most vulnerable. This work will help better quantify the cost of expanding services to more persons with an SPMI and children with an SED.

The variability in the use of state psychiatric hospitals will also be addressed through the implementation of improved CMHC screening and assessment process for state hospital admissions. In addition, SRS will seek to improve the training of CMHC staff who are responsible for crisis response and screening.

The pressure caused by the continual increase in state psychiatric hospital admissions can be relieved in part by the development of more comprehensive crisis mental health services. SRS will be doing a statewide assessment of crisis services needs using the crisis array developed by a Hospital and Home Work Team. In addition, SRS will be examining what policies or practices can be changed to make it more likely that persons admitted to state psychiatric services from such placements as nursing facilities, developmental disability providers, or traumatic brain injury programs can return to their original placement once the person's inpatient treatment has been completed. Comprehensive and effective care coordination also needs to be provided to persons discharged from state psychiatric hospitals who are experiencing substance abuse.

The declining availability of community hospital inpatient psychiatric programs coupled with the rising state psychiatric hospital admissions supports the need for SRS' budget enhancement request to pay Medicaid payments for longer lengths of stay and for persons who are uninsured. Increased children's admissions to KVC STAR needs to be thoroughly researched. Also, increased costs of PRTFs also suggest the need to measure how PRTF services positively impact the outcomes for the children and adolescents they serve.

TriWest's independent evaluation of the 1915 (b) waiver made a series of recommendations to improve community based mental health managed care. SRS will seek to implement all of those recommendations. Of particular note is TriWest's recommendation to enhance and improve utilization review processes. CMS has completed its review of the SED Waiver and, while SRS substantially met all six assurances, CMS has a list of recommendations for improving oversight of the SED waiver that will need to be implemented. SRS will also need to address those recommendations.

In addition to TriWest's specific recommendations, the 1915 (b) waiver renewal process brought to light the need to improve the use of the SED Waiver by children in SRS custody and support increased use of Peer Support.

SRS and KHS have also identified the need to reduce the bureaucratic burden related to the beneficiary registration process now being used and to increase scrutiny of care coordination that may be lost as a result of more private outpatient practitioners.

NF/MHs continue to provide services in the same manner as they have for the last 20 years. Mental health services have progressed significantly since then. It is now time to develop a new vision for NF/MHs that utilizes the skills, talents and dedication of the NF/MH staff with the rest of the mental health service system to better help persons with mental illness recover.

Kansas' public mental health service system is highly complex and interactive. It is critical that this system provide the services people with mental illness need to recover and live safe, healthy, successful, self-determined lives in their homes and communities. It is believed the actions described in this report will be positive steps in this direction.

## ATTACHMENT A

### **Severe and Persistent Mental Illness (SPMI)**

To meet functional criteria for SPMI, persons with a primary diagnosis in Category A or B must, as a result of their qualifying diagnosis, demonstrate impaired functioning through use of the following assessment. Those with a primary diagnosis in Category B must meet these criteria as well as criteria outlined in Step 3.

### **Method to determine SPMI**

**PURPOSE:** To insure that adults with Severe and Persistent Mental Illness (SPMI), or who are most at risk of developing SPMI, are promptly and accurately identified.

To insure that those most in need are offered the full array of community- based mental health services necessary to successfully manage their illness, support their recovery process, and live meaningful lives in their community.

**APPROACH:** Apply two main areas of assessment to determine an individual's status as meeting criteria for SPMI: (1) diagnostic criteria, and (2) functional and risk criteria.

- Step One: Apply diagnostic criteria to determine an individual's identification as meeting initial criteria for the CSS target population. To meet diagnostic criteria for SPMI, individuals must be assessed to determine whether they have a principal diagnosis in either Category A or Category B.

### ***Category A Diagnoses:***

295.10 Schizophrenia, Disorganized Type  
295.20 Schizophrenia, Catatonic Type  
295.30 Schizophrenia, Paranoid Type  
295.60 Schizophrenia, Residual Type  
295.70 Schizoaffective Disorder  
295.90 Schizophrenia, Undifferentiated Type  
296.34 Major Depressive Disorder, Recurrent, Severe, with Psychotic Features  
Bipolar I Disorders that are Severe, and/or with Psychotic Features  
298.9 Psychotic Disorder NOS

### ***Category B Diagnoses:***

All Other Bipolar I Disorders, not listed in Category 1  
296.89 Bipolar II Disorder  
296.23 Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features  
296.24 Major Depressive Disorder, Single Episode, With Psychotic Features  
296.32 Major Depressive Disorder, Recurrent, Moderate  
296.33 Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features  
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296.35 Major Depressive Disorder, Recurrent, In Partial Remission  
296.36 Major Depressive Disorder, Recurrent, In Full Remission  
297.10 Delusional Disorder  
300.21 Panic Disorder With Agoraphobia  
300.3 Obsessive-Compulsive Disorder  
301.83 Borderline Personality Disorder

***Category C Diagnoses:***

The following diagnoses (as a principal diagnosis) are excluded from those defining an individual as having SPMI or being most at risk of SPMI.

Anti-Social Personality Disorder  
Behavior Disorders  
Developmental Disorders  
Neurological/General Medical Disorders  
Substance Abuse Disorders  
Psychotic Disorder [Substance-induced only]  
DSM-IV-R "V" Codes

- **Step Two:** To meet functional criteria for SPMI, persons with a primary diagnosis in Category A or B must, as a result of their qualifying diagnosis, demonstrate impaired functioning through use of the following assessment. For those with a primary diagnosis in Category A who do meet the functional criteria listed below, no further assessment is needed to determine eligibility for CSS. Those with a primary diagnosis in Category B must meet these criteria as well as criteria outlined in Step 3.

Impaired functioning<sup>1</sup> is evidenced by meeting at least one (1) of the first three criteria, and at least three (3) of the criteria numbered 4 through 9 that have occurred on either a continuous or intermittent basis over the last two years:

1. Required inpatient hospitalization for psychiatric care and treatment more intensive than outpatient care at least once in her/his lifetime;
2. Experienced at least one episode of disability requiring continuous, structured supportive residential care, lasting for at least two months (e.g. a nursing facility, group home, half-way house, residential mental health treatment in a state correctional facility);
3. Experienced at least one episode of disability requiring continuous, structured supportive care, lasting at least two months, where the family, significant other or friend of the consumer provided this level of care in lieu of the consumer entering formalized institutional services. (In this case, the intake assessment must fully document the consumer's level of severe disability and lack of functioning that required the family or other person to provide this level of care).
4. Has been unemployed, employed in a sheltered setting, or has markedly limited skills and a poor work history;
5. Requires public financial assistance for their out-of-institutional maintenance and is unable to procure such financial assistance without help;
6. Shows severe inability to establish or maintain a personal support system,

evidenced by extreme withdrawal and social isolation;

7. Requires help in instrumental activities of daily living such as shopping, meal preparation, laundry, basic housekeeping, and money management;

8. Requires help in attending to basic health care regarding hygiene, grooming, nutrition, medical and dental care, and taking medications. (Note: this refers to the lack of a basic skill to accomplish the task, not to the appropriateness of dress, meal choices, or personal hygiene);

9. Exhibits inappropriate social behavior not easily tolerated in the community, which results in demand for intervention by the mental health or judicial systems (e.g. screaming, self-harm)

Adults that would have met functional impairment criteria during the referenced time period without the benefit of treatment or other support services are included here, abusive acts, inappropriate sexual behavior, verbal harassment of others, physical violence toward others).

### Step three: Risk Assessment

Completion of the risk assessment.

**DIRECTIONS:** For each item listed below: (1) determine with the person being assessed whether the item applies to her/his life situation; (2) circle the correct number for the item, based on the time period that applies; and (3) enter the number in the box labeled “Score”.

Risk Factor	<u>Circle a number if the item applies</u>		Score
	Within the past 30 days	Between 31 and 180 days	
1. Has been discharged from inpatient psychiatric hospitalization.	5	3	
2. History of suicide attempts/life threatening self harm	5	5	
3. Documented threats of physical harm to others without follow through	2	1	
4. Has been released from jail or prison due to a crime involving physical harm to self or others that was related to psychiatric symptoms	3	1	
5. Experienced severe to extreme impairment due to physical health status (Impairment may be due to chronic health problems and/or frequency and severity of acute illnesses)	2	1	

6. Experienced severe to extreme impairment in thought processes (as evidenced by symptoms such as hallucinations, delusions, tangentiality, loose associations, response latencies, incoherence)	5	3	
7. Experienced severe to extreme impairment due to abuse of drugs and/or alcohol (Abuse is NOT use: the abuse of substances must seriously interfere with daily functioning, i.e. in employment, family or social relationships, housing status, income, goal attainment, etc.)	2	1	
8. History of self-mutilating behavior	3	2	

<b>NOTE:</b> You may mark only <u>ONE</u> of the following housing statuses, if one applies:	<b>Within the past 30 days</b>	<b>Between 31 and 180 days</b>	<b><u>Score</u></b>
9. Currently homeless or had an incident of homelessness (defined as lack of an overnight, fixed address resulting in sleeping in places not fit for human habitation, i.e. streets, cars, etc., or sleeping in a homeless shelter)	4	2	
10. Currently residing in an RCF or has resided in an RCF (RCF's are state-licensed Residential Care Facilities providing congregate living to adults with mental illness. These include NFMH's, group homes, Adult Care Homes, etc.)*	3	1	
11. Currently at imminent risk of homelessness and/or placement in an RCF	2	1	
	<b>TOTAL SCORE:</b>		

\* **NOTE:** For #10, stays in an RCF for purposes of crisis stabilization or respite are not considered if the stay is short in duration (30 days or less) and the person has, throughout their stay, a fixed, overnight address to which they will return upon discharge.

**Circle Score:**                      **Risk Assignment:**    **CSS Eligibility Status:**

10 or higher                      High Risk                      YES

9 or less                      Low Risk                      NO

This tool is meant as a screening device, not the final and only assessment of risk. Should a worker or consumer rank him/her at a higher level of risk than is indicated, the score should be changed to reflect that level of risk and the change and rationale for it be documented below:

## ATTACHMENT A

### **Criteria for Serious Emotional Disturbance (SED)**

The term serious emotional disturbance refers to a diagnosed mental health condition that substantially disrupts a child's ability to function socially, academically, and/or emotionally.

Complete the following checklist to determine if the youth has SED.

#### **Check yes or no on #1 - 3 to determine if the youth has SED:**

YES    NO

#### **1. AGE:**

—      —

The youth is under age 18, or under the age of 22 and has been receiving mental health services prior to the age of 18 that must be continued for optimal benefit.

YES    NO

#### **2. DURATION and DIAGNOSIS:**

—      —

The youth currently has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the most current DSM.

Disorders include those listed in the most current DSM or the ICD - 9 equivalent with the exception of DSM - IV "V" codes, substance abuse or dependence, and developmental disorders, unless they co-occur with another diagnosable disorder that is accepted within this definition.

Diagnosis \_\_\_\_\_

YES    NO

#### **3. FUNCTIONAL IMPAIRMENT**

—      —

The disorder must have resulted in functional impairment which substantially interferes with or limits the youth's role or functioning in family, school, or community activities.

Functional impairment is defined as difficulties (internalizing and externalizing) that substantially interfere with or limit a youth from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included.



Youth that would have met functional impairment criteria without the benefit of treatment or other support services are included in this definition.

Which of the following functional areas has been disrupted as a direct result of the child's mental health condition? **(Examples are not intended to be all inclusive, and more than one can be marked).**

- 9 School (for example: exhibiting behaviors that interfere with the child's ability to perform such as inattentive in class, unable to sit in one place, unable to concentrate, withdrawn at school to the point that the child's ability to function at school is impacted, accumulating sick days as a result of being overwhelmed/depressed which places the student at risk for truancy, in-school suspension, out-of-school suspension)
- 9 Family (for example: at-risk of out-of-home placement, physical aggression at home, suicidal, isolative and withdrawn to the point that youth is not engaging in day to day family activities)
- 9 Community (for example: impairment necessitates law enforcement contact such as youth is running away due to delusional symptoms; unable to or serious difficulty participating in regular community and/or peer activities due to behavior, isolating from peers)

**EXCLUSIONS: Functional impairment does not qualify if it is a temporary response to stressful events in the youth's environment. Functional impairment also does not qualify if it can be attributed solely to intellectual, physical, or sensory deficits.**

Youth meets the criteria for SED:	YES _____	NO _____
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